

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8705 CERTIFICATE OF DEATH 08699

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 5 yrs. 2 mos. 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Caroline c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ridgley d. STREET ADDRESS Route 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Louise		First Middle Last Agree		4. DATE OF DEATH Month 8 Day 20 Year 1961			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 20, 1907			
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Samuel Pinkett		14. MOTHER'S MAIDEN NAME Margaret ?					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO DUE TO		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. ----- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----			
20f. (City or town) -----		20g. (County) -----		20h. (State) -----			
21. I certify that (I) (this hospital) attended the deceased from 6/13 to 8/20 , 19 61 , that (I) (we) last saw the deceased alive on 8/20 , 19 61 , and that death occurred at 7:05 A.M. from the causes and on the date stated above.							
22a. SIGNATURE [Signature]		M.D. L. Benedict, M. D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 8/21/61			
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) -----		23b. DATE THEREOF 8/21/61		23c. NAME OF CEMETERY OR CREMATORY Spring Grove			
23d. LOCATION (City, town or county) Denton		23e. (State) MD					
24. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS J. V. Moore & Son		25a. REC'D BY REGISTRAR Aug 24 '61			
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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July 20, 1907

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in item 18. Give Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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FOR STATE
HEALTH DEPT.

tem 20 Film 293 8-24-61
Items 20&21 Film 301 11-17-61
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8706 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08700

1. PLACE OF DEATH a. COUNTY A. A. County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 8 Madison Place, Annapolis, Md. c. LENGTH OF STAY IN lb Anne Arundel Gen. Hospital d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Annapolis, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY A. A. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 8 Madison Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anthony S. Adams		4. DATE OF DEATH Month 8 Day 17 Year 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-14-61
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		9b. KIND OF BUSINESS OR INDUSTRY none	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Thomas Adams		14. MOTHER'S MAIDEN NAME Joyce Peddicord	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT John T. Adams - Father- same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Head injury 936.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20b: Hit in head with bottle by sibling 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Exact nature unknown, but may have been struck by sibling bottle of 13 mo. old brother when left in room with this boy 20c. TIME OF INJURY Month, Day, Year Hour e.m. Aug. 16 p.m. Unknown 19 61 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State) Annapolis A.A. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S SIGNATURE William V. Lovitt, Jr., M.D. NAME (Type) DATE SIGNED 8-17-61 Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 19, 61	
22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		22d. LOCATION (City, town, or country) (State) Glen Burnie Maryland	
23. FUNERAL DIRECTOR Hopping Funeral Home		24a. REC'D BY REGISTRAR AUG 21 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Knaus		DATE	

VS. A15ME
5M 9/60

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UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

(M)

(1)

Memorandum

TO :

FROM :

SUBJECT :

DATE :

BY :

FOR :

1-11-61

none

none

John T. ...

John T. ...

none

none

head injury

...

...

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...

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8707

08701

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>3 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Bradley</u> Last <u>Alvey Sr.</u>		4. DATE OF DEATH Month <u>August</u> Day <u>26</u> Year <u>19 61</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jan. 16, 1890</u> 9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer Ret.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>A. A. Co. Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>		13. FATHER'S NAME <u>Howerton C. Alvey</u>					
14. MOTHER'S MAIDEN NAME <u>Corinne Carr</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>1</u> 17. INFORMANT <u>Pauline Steele Alvey</u> Address <u>(2)</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Arteriosclerotic hypertensive</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <u>Cardiovascular disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 27, 1956</u> , to <u>Aug. 26, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug. 26, 1961</u> , and that death occurred at <u>8:32 M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Sylvia M. Lim</u>		22b. DATE SIGNED <u>8/26/61</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. Sylvia Lim</u>			
22d. ADDRESS <u>Mayo Rd. Edgewater, Md.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>8-28-1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Mayo Memorial</u> 23d. LOCATION (City, town or county) (State) <u>Mayo Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sins</u>		25a. REC'D BY REGISTRAR <u>Aug 29 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician. The law further requires that the death certificate be signed by the funeral director. The law also requires that the death certificate be signed by the funeral director. The law also requires that the death certificate be signed by the funeral director.

(M)

Anne Arnold

Annapolis

Anne Arnold General

(I)

Richard

White

Male

Bradley

Jan. 10, 1890

Alvey

August 25

61

Anne Arnold

Harvard

Worcester

3 yrs.

1890

3703

W. Sylvia Ann

May 10

Worcester, Mass.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8708

18702

1. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MARYLAND</i> b. COUNTY <i>Anne Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brooklyn Park</i>				c. LENGTH OF STAY IN 1b <i>X Brooklyn Park</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3 Hammond Lane</i>				d. STREET ADDRESS <i>3 Hammond Lane</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Maggie</i> Middle <i>M.</i> Last <i>ANDERSON</i>				4. DATE OF DEATH Month <i>5</i> Day <i>5</i> Year <i>1961</i>			
5. SEX <i>F</i>		6. COLOR OF RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug. 8, 1872</i>	
9. AGE (In years last birthday) <i>85</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>H.D.</i>			
11. BIRTHPLACE (State or foreign country) <i>M.D.</i>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>Wm Goodrich</i>				14. MOTHER'S MAIDEN NAME <i>UNK</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
17. INFORMANT <i>Family</i>				Address <i>Same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> DUE TO (b) <i>(Blindness also).</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hematuria of unknown cause</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>Morton M. Krieger</i>				22b. DATE <i>Aug 5, 1961</i>			
22c. PHYSICIAN'S NAME (Type) <i>MORTON M. KRIEGER M.D.</i>				22d. ADDRESS <i>5010 Ritchie Hwy Baltimore 25 Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8-9-61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cem</i>		23d. LOCATION (City, town, or county) (State) <i>Balto Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Mc Cubby Funeral Home 130 E. Fort Ave</i>				25a. REC'D BY REGISTRAR DATE <i>AUG 9 '61</i>			
25b. REGISTRAR'S SIGNATURE <i>Carlton L. H...</i>							

MEDICAL CERTIFICATION

1

OP

1010

CONTINUED OF

2108

(M)

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs.]



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08703

8709

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	c. LENGTH OF STAY IN 1b <u>15 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Melvin Road - Rt. 3</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Long</u> Last <u>Asbury</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>7</u> Year <u>19 61</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 26 1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	9. AGE (In years lost birthday) <u>73</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles N. Long</u>		14. MOTHER'S MAIDEN NAME <u>Bettie Gooch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mr Mary Louise Briscoe - Annapolis Md.</u>	
17. INFORMANT <u>Mr Mary Louise Briscoe - Annapolis Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cornary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ONE HOUR</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/7</u> , 19 <u>61</u> , to <u>8/7</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>8/7</u> , 19 <u>61</u> , and that death occurred at <u>1:30 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>95 Cathedral Street Annapolis Maryland</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Philip Briscoe</u>		PHYSICIAN'S NAME (Type) <u>Philip Briscoe</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Aug 8, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Port Republic, Ches. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>G.A. Harkness</u>		ADDRESS <u>2501 Nuttall Rd.</u>	24a. REC'D BY REGISTRAR <u>Aug 8 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the pages. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8710

08704

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		d. STREET ADDRESS 126 Conduit St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Doris C BASIL		4. DATE OF DEATH Month August		Day 22		Year 19 61		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 20, 1912		9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months 4		IF UNDER 24 HRS. Days 9		Hours 15		Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tel Operator		10b. KIND OF BUSINESS OR INDUSTRY Message Center		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Edward R. Knadler		14. MOTHER'S MAIDEN NAME Nellie Phelps		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 219 16 1128		17. INFORMANT Mr. Thomas R. Basil- Husband- same as # 2		Address same as # 2		INTERVAL BETWEEN ONSET AND DEATH 3 days		4 months			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199X DUE TO Paralytic ileus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Diffuse metastatic malignant disease DUE TO (c) Acute thrombotic phlebitis		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute thrombotic phlebitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20b. (City or town) Annapolis		(County) Anne Arundel		(State) Md.					
21. I certify that (I) was attended the deceased from Aug. 19, 1961 to Aug. 21, 1961 , that (I) was saw the deceased alive on Aug. 21, 1961 , and that death occurred at 4:15 A.M. from the causes and on the date stated above.		22a. SIGNATURE Gerard Church		M.D. Dr. Gerard Church		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/22/61		22c. PHYSICIAN'S NAME (Type) Dr. Gerard Church		22d. ADDRESS 121 Cathedral St., Annapolis, Md.		(State) Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 25, 1961		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town or county) Annapolis, Md.		(State) Md.		25a. REC'D BY REGISTRAR AUG 25 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Knecht		25c. REGISTRAR'S SIGNATURE Arthur L. Knecht		25d. REGISTRAR'S SIGNATURE Arthur L. Knecht		25e. REGISTRAR'S SIGNATURE Arthur L. Knecht							
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR AUG 25 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Knecht		25c. REGISTRAR'S SIGNATURE Arthur L. Knecht		25d. REGISTRAR'S SIGNATURE Arthur L. Knecht		25e. REGISTRAR'S SIGNATURE Arthur L. Knecht		25f. REGISTRAR'S SIGNATURE Arthur L. Knecht		25g. REGISTRAR'S SIGNATURE Arthur L. Knecht		25h. REGISTRAR'S SIGNATURE Arthur L. Knecht							

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8711

CERTIFICATE OF DEATH

08705

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>6 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> d. STREET ADDRESS <u>1342 Girard Street N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Henry George BAUER</u>			4. DATE OF DEATH Month <u>August</u> Day <u>31</u> Year <u>19 61</u>				
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/11/07</u> 9. AGE (In years last birthday) <u>54</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Parts Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Ferdinand C. Bauer</u>			14. MOTHER'S MAIDEN NAME <u>Johannah Carsten</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-10-2003</u>		17. INFORMANT <u>Pauline Bauer</u> Address <u>same as #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive retroperitoneal hemorrhage</u> DUE TO (b) <u>ruptured abdominal aneurysm, arteriosclerotic.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) <u>Willard F. Smith</u> attended the deceased from <u>Aug 30, 1961</u> to <u>Aug 31, 1961</u> , that (I) <u>last</u> saw the deceased alive on <u>Aug 30, 1961</u> , and that death occurred <u>5:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Willard F. Smith</u>			22b. DATE SIGNED <u>8/31/61</u>				
22c. PHYSICIAN'S NAME (Type) <u>Willard F. Smith</u>			22d. ADDRESS <u>Shadyside, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>9/2/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cem. Prince Georges, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>			25a. REC'D BY REGISTRAR <u>SEP 5 '61</u>				
ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>			25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed in by the funeral director. This certificate has been signed by the attending physician and completed in by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed in by the funeral director. This certificate has been signed by the attending physician and completed in by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed in by the funeral director. This certificate has been signed by the attending physician and completed in by the funeral director.

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may be completed by the hospital attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>406 Howard Ave. ?</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arnold M.D.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Arnold (Birchwood)</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>OLIVER</i> First <i>Blockinger</i> Middle Last		4. DATE OF DEATH <i>8-2-61</i> Month Day Year	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 23, 1909</i>
9. AGE (In years last birthday) <i>52</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, except retired) <i>Sheet Metal</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Pixie Mfg. Co.</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>John Blockinger</i>		14. MOTHER'S MAIDEN NAME <i>Linda Ebert</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <i>yes</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i> DUE TO <i>arteriosclerotic C.V. disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1960</i> 19 to <i>1961</i> 19, that (I) (we) last saw the deceased alive on <i>6-8-61</i> , and that death occurred at <i>24</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Robert R. Halpin</i> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Robert R. Halpin</i>		22d. ADDRESS <i>Severna Park Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>53 August 61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		23d. LOCATION (City, town, or county) (State) <i>Brooklyn P.D. Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>R. V. Singleton</i>		25a. REC'D BY REGISTRAR <i>Glen Burnie, Md.</i> DATE <i>AUG 3 '61</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>			

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8712

Item 14 Film G292 8/9/61 ink

08706

20730

DEPARTMENT OF AGRICULTURE

1915

(M)

1. The first of the three main groups of plants is the group of plants which are known as the "hardwoods". These plants are characterized by the fact that they have a very hard, dense wood which is very resistant to decay and fire. They are also characterized by the fact that they have a very long life span, often living for many centuries. The second group of plants is the group of plants which are known as the "softwoods". These plants are characterized by the fact that they have a very soft, light-colored wood which is very susceptible to decay and fire. They are also characterized by the fact that they have a very short life span, often living for only a few decades. The third group of plants is the group of plants which are known as the "conifers". These plants are characterized by the fact that they have a very hard, dense wood which is very resistant to decay and fire. They are also characterized by the fact that they have a very long life span, often living for many centuries.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is complete. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8713

08707

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St Margarets</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>AA</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St Margarets</i> d. STREET ADDRESS <i>19 F. D. Annapolis</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>S.</i> Last <i>Bowdoin</i>				4. DATE OF DEATH Month <i>Aug</i> Day <i>18</i> Year <i>1961</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 22-1869</i>	
9. AGE (In years, if UNDER 1 YEAR, give birth date) <i>92</i> yrs. Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Banker Ret.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Banking</i>		11. BIRTHPLACE (County & State or foreign country) <i>Paris France</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>James Bowdoin</i>		14. MOTHER'S MAIDEN NAME <i>Charlotte K. Costobadis</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs Fritz Huber</i>		Address <i>Hudson N. Y.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vascular accident.</i> DUE TO (b) <i>gunshot arteriovenous</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>May 18</i> 19 <i>59</i> to <i>August 18</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>Aug 18</i> 19 <i>61</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Emily H. Wilson</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8-21-1961</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cem</i>		23d. LOCATION (City, town or county) (State) <i>Washington D C</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Taylor Soxa</i>				ADDRESS <i>Annapolis Md.</i>		25a. REC'D BY REGISTRAR DATE <i>AUG 22 '61</i>	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hane</i>			

(M)

6313

St. Margaret
G. O.

James Robertson
100 miles W. of London
at

St. Margaret
G. O.
St. Margaret
G. O.

James Robertson
100 miles W. of London
at

James Robertson
100 miles W. of London
at

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68708

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FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 26		c. LENGTH OF STAY IN 1b All his life		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Same		b. COUNTY Same		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same		d. STREET ADDRESS Same		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Stanley		First		Middle		Last		4. DATE OF DEATH 8		Month 17		Day 1961		Year									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-11-20		9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Liquor Store Operator		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) A.A. County, Baltimore 26		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frank Bozek		14. MOTHER'S MAIDEN NAME Josephine Washlesski		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes W.W. II		16. SOCIAL SECURITY NO. 218-85-478		17. INFORMANT Mr. John Bozek 7214 Marley Neck Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) 8-17-61																							
ACTUAL SIGNATURE William V. Lovitt, Jr.				EXAMINER'S NAME (Type) William V. Lovitt, Jr.				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Aug. 21, 1961				22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery				22d. LOCATION (City, town, or country) (State) Ritchie Hwy. A. A. Co., Md.			
23. FUNERAL DIRECTOR George J. Gonce				ADDRESS 4001 Ritchie Hwy. (25)				24a. REC'D BY REGISTRAR AUG 23 '61				24b. REGISTRAR'S SIGNATURE Arthur L. Hume											

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, and the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 48 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is complete. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8715

08709

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> c. LENGTH OF STAY IN lb <u>23 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> d. STREET ADDRESS <u>238 KING GEORGE STREET</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>William Van Courtlandt BRANDT</u> First Middle Last 4. DATE OF DEATH Month <u>AUGUST</u> Day <u>8</u> Year <u>19 61</u>			5. SEX <u>MALE</u> 6. COLOR OR RACE <u>CAUC.</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>8 NOVEMBER 1888</u> 9. AGE (in years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Business Manager</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Battery Manufacturing</u> 11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u> 12. CITIZEN OF WHAT COUNTRY? <u>United States</u>			13. FATHER'S NAME <u>Nathaniel Fields BRANDT</u> 14. MOTHER'S MAIDEN NAME <u>Josephine (n) HEWLETT</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WW II</u> 16. SOCIAL SECURITY NO. <u>WW II</u> 17. INFORMANT <u>Sara C. BRANDT, 238 King George St., Annapolis,</u> Address <u>Maryland</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Coma</u> DUE TO <u>Portal cirrhosis and</u> Conditions, if any, which gave rise to immediate cause (b) <u>metastatic Carcinoma</u> (c) <u>metastatic Carcinoma</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>INTERVAL BETWEEN ONSET AND DEATH</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21. I certify that (I) (this hospital) attended the deceased from <u>17 July</u> , 19 <u>61</u> to <u>8 August</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8 August</u> , 19 <u>61</u> , and that death occurred <u>11:08 PM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Stephen B. Hiltabidle</u> 22c. PHYSICIAN'S NAME (Type) <u>Stephen B. HILTABIDLE, LCDR MC</u>			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND</u> 22b. DATE SIGNED <u>9 AUG 61</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>8-11-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>U.S.N. Arlington National</u> 23d. LOCATION (City, town or county) <u>Arlington</u> (State) <u>Va</u>			24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons Annapolis, Md.</u> 25a. REC'D BY REGISTRAR <u>DATE AUG 11 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Cynthia S. Kraus</u>		

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1992-1993

U.S. NAVAL HOSPITAL, DANANG, VIETNAM

751037 1975 11 14 1400 111111

1990-1991

TOWNSHIP 23 N 13 E 12 S 12 T 23 N

It is not clear that the above is a correct interpretation of the text.

11-11-11

Source: *Journal of the American Statistical Association*, 1990, 85, 103-113.

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TABLE 1. *Continued*

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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08710

1. PLACE OF DEATH a. COUNTY A A MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY A A			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS MD				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS 10			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 702 SEVERN AVE.				d. STREET ADDRESS 702 SEVERN AVE			
3. NAME OF DECEASED (Type or print) First GEORGE Middle T. Last BROOKS				4. DATE OF DEATH Month 8- Day 6 Year 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 26-1890	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min.		IF UNDER 24 HRS. Months 70 Days 70 Hours 70 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER RET.				10b. KIND OF BUSINESS OR INDUSTRY PAINTER		11. BIRTHPLACE (State or foreign country) Annapolis Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME SAMUEL W. BROOKS				14. MOTHER'S MAIDEN NAME FLORENCE BRADY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT MRS WM T. GARDNER				Address 142 GIBSON Rd, ANNAPOLIS MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Arterio Sclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) 1 yr. DUE TO (c) 1 yr.						INTERVAL BETWEEN ONSET AND DEATH 4 hrs 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) June 10 1959 to 8-6-1961				20g. (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 10 1959 to 8-6-1961 , that (I) (we) last saw the deceased alive on 8-5-1961 , and that death occurred at 10 AM , from the causes and on the date stated above.							
22a. SIGNATURE James R. Martin				22b. DATE SIGNED 8-8-61		22c. ADDRESS 6 SHAW ST. ANNAPOLIS, MD.	
22c. PHYSICIAN'S NAME (Type) JAMES R. MARTIN				22d. ADDRESS 6 SHAW ST. ANNAPOLIS, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-11-1961		23c. NAME OF CEMETERY OR CREMATORY Edwards Chapel		23d. LOCATION (City, town, or county) (State) Riva Road A A Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sins				25a. REC'D BY REGISTRAR DATE AUG 11 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 4 mos. 27 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 605 Carrollton Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ruth First Middle Last Burnside		4. DATE OF DEATH Month Day Year 8 11 61	
5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 20, 1929 31 yrs.	
9. AGE (In years last birthday) 31		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Ward		14. MOTHER'S MAIDEN NAME Carrie Monk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right Lower Lobe Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b) Cervical Carcinoma (c) Schizophrenic Reaction, Paranoid Type PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic Reaction, Paranoid Type		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. 12/19 p.m. 4:20		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/19 , 19 60 , to 8/11 , 19 61 , that (I) (we) last saw the deceased alive on 8/11 , 19 61 , and that death occurred at 4:20 from the causes and on the date stated above.			
22a. SIGNATURE L. Benedict, M. D.		22b. DATE SIGNED 8/11/61	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) 8/14/61		23b. DATE THEREOF 8/14/61	
23c. NAME OF CEMETERY OR CREMATORY Calverton		23d. LOCATION (City, town or county) (State) Baltimore Md	
24. FUNERAL DIRECTOR'S SIGNATURE Morton D. Zell		25a. REC'D BY REGISTRAR AUG 15 '61	
ADDRESS 918 Penn. ave		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

11/30

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Baltimore City

Maryland

James H. H. H.

Baltimore

4 Nov. 27 days

Greenwald

605 Greenwald Avenue

Greenwald State Hospital

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Baltimore

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Negro

Female

December 20, 1929

Maryland

U.S.A.

Carrie Monk

David Monk

None

Hospital Records

Unknown

Unknown

Right lower lobe pneumonia

Cervical carcinoma

Schizophrenic Reaction, Paranoid Type

x

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A:30

11/30

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11/30

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x

Greenwald State Hospital

I. H. H. H.

11/30

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No. 08712

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Woodland Beach</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>White</u> Last <u>BUSSER</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>20</u> Year <u>1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 28 1907</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building Const.</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>FRANK BUSSE</u>			
14. MOTHER'S MAIDEN NAME <u>KATIE WHITE</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>			
16. SOCIAL SECURITY NO. <u>160-16-7658</u>				17. INFORMANT <u>Alma R. Busser- Wife- same ad # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial insufficiency</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>coronary artery disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 20, 1961</u> , to <u>August 20, 1961</u> , that I last saw the deceased alive on <u>not at all</u> , 19 <u>61</u> , and that death occurred at <u>6:13 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Emily Wilson MD</u>		ADDRESS (Street, city or town, state) <u>(acting coroner)</u>		DATE SIGNED <u>8-20-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 23, 61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Ma.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 23 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

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VS A15 (4)
15M 10/57

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. It must be signed by the hospital or attending physician.

DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the funeral director.

After death: Page 4

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08713

2719

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lanham</i>		c. LENGTH OF STAY IN 1b <i>20 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>203 Valley Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>-</i> Last <i>Calderhead</i>		4. DATE OF DEATH Month <i>Aug</i> Day <i>8</i> Year <i>1961</i>	
5. SEX <i>m</i>	6. COLOR OR RACE <i>w</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 7-1907</i>
9. AGE (In years last birthday) <i>54 yrs.</i>		10. IF UNDER 1 YEAR Months <i>5</i> Days <i>1</i> Hours <i>3</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electrician</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Chemical Co.</i>	
11. BIRTHPLACE (State or foreign country) <i>Chicago Ill</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Wm S. Calderhead</i>		14. MOTHER'S MAIDEN NAME <i>Agusta Graham</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>453-05-3351</i>	
17. INFORMANT <i>Margaret Calderhead Same</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis</i> DUE TO (b) <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr -</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1941</i> , 19 <i>Aug 8</i> , 1961, that I last saw the deceased alive on <i>Aug 8</i> , 1961, and that death occurred at <i>7:55 P.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Charles L. Ball Jr.</i>		DATE SIGNED <i>8/8/61</i>	
PHYSICIAN'S NAME (Type) <i>Charles L. Ball, Jr. M.D.</i>		ADDRESS (Street, city or town, state) <i>203 W. Maple Rd Lanham Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>8-11-61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Elkridge, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Cook, Inc., 1217 St. Paul Street</i>		24a. REC'D BY REGISTRAR <i>AUG 11 '61</i>	
24b. REGISTRAR'S SIGNATURE <i>Charles L. Kraus</i>			

MEDICAL CERTIFICATION

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MADE IN U.S.A.

LYNN BOMID

1935-1936

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Name of Deceased		Lynn Bomid	
Date of Birth		1935-1936	
Place of Birth			
Sex		Female	
Race		White	
Marital Status		Single	
Occupation			
Cause of Death			
Date of Death			
Place of Death			
Signature of Physician			
Signature of Registrar			
Signature of Coroner			
Signature of Medical Examiner			
Signature of Funeral Home			
Signature of Burial Place			
Signature of Cemetery			
Signature of Interment			
Signature of Burial			
Signature of Cremation			
Signature of Other			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 2 would be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8720

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08714

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>C. A. General Hosp</u>		d. STREET ADDRESS <u>59 Shaw St. 1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Larry</u> Middle <u>Calvert</u> Last <u>Calvert</u>		4. DATE OF DEATH Month <u>8</u> Day <u>9</u> Year <u>1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-16-1954</u>	
9. AGE (In years last birthday) <u>7</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u> Hours <u>19</u> Min. <u>61</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Eugene Calvert</u>		14. MOTHER'S MAIDEN NAME <u>Sachel Calvert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Sachel Calvert</u>		Address <u>59 Shaw St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation</u> DUE TO <u>Strangulation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Strangulation</u> DUE TO <u>Strangulation</u> cause lost. (c) <u>Strangulation</u> INTERVAL BETWEEN ONSET AND DEATH <u>Strangulation</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Strangulation</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>While swimming</u>	
20c. TIME OF INJURY Month, Day, Year <u>8/9/61</u> Hour <u>8:15</u> a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Strangulation</u>		20f. (City or town) <u>Annapolis</u> (County) <u>Prince Georges</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Chamber</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. N. M. M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8/9/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-13-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wopes Chapel</u>		22d. LOCATION (City, town, or county) <u>Edgewater, Md.</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		ADDRESS <u>11 - Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>Aug 14 1961</u>		24b. REGISTRAR'S SIGNATURE <u>William L. Reese</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(M)

Form with multiple sections for medical examination and death certification, including fields for patient information, medical history, and examiner's signature.

1. Name of Deceased: _____

2. Sex: ☐ Male ☐ Female

3. Age: _____

4. Date of Birth: _____

5. Place of Birth: _____

6. Race: _____

7. Occupation: _____

8. Cause of Death: _____

9. Manner of Death: _____

10. Signature of Medical Examiner: _____

11. Date: _____

12. Location: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased is not in the hospital or attending physician's office, the certificate may be retained by the hospital or attending physician and completed by the attending physician and filed in by the funeral director. TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completed by the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
8721					08715				
Item 2 Film G293 8/31/61 ink									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) b. STATE <u>Maryland</u> <u>Florida</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL / / Riva / Miami</u> d. STREET ADDRESS <u>269 N. E. 20th. St.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>12 days</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>					e. DATE OF DEATH <u>August 23 1961</u>				
3. NAME OF DECEASED (Type or print) <u>Joseph S. CARDON</u>					4. DATE OF DEATH <u>August 23 1961</u>				
5. SEX <u>Male</u>					6. COLOR OR RACE <u>White</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>3-20-1883</u>				
9. AGE (In years last birthday) <u>78</u> yrs.					10. IF UNDER 1 YEAR Months Days				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>SALESMAN RET.</u>				
11. BIRTHPLACE (County & State, or foreign country) <u>PENNA.</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				
13. FATHER'S NAME <u>CLEMENT CARDON</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>					16. SOCIAL SECURITY NO. <u>—</u>				
17. INFORMANT <u>MRS. Lulu W. CARDON #2</u>					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> 332 X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>ARTERIOSCLEROSIS, GENERAL</u> DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE; GOUT</u>					INTERVAL BETWEEN ONSET AND DEATH <u>24 HOURS</u> <u>UNKNOWN</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (the doctor) attended the deceased from <u>Aug. 11, 1961</u> to <u>Aug. 23, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug. 23, 1961</u> , and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above.					22a. SIGNATURE <u>Edward S. Beck</u> M.D.				
22b. PHYSICIAN'S NAME (Type) <u>Edward S. Beck</u>					22c. ADDRESS <u>71 Franklin St., Annapolis, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>					23b. DATE THEREOF <u>8-26-61</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. LINCOLN</u>					23d. LOCATION (City, town or county) (State) <u>PRINCE GEORGE CO. MD.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. G. Lott & Sons Annapolis, Md.</u>					25a. REC'D BY REGISTRAR <u>Aug 28 '61</u>				
25b. REGISTRAR'S SIGNATURE <u>William S. Kline</u>									

VR A15 (4)
15M 9/60

M

1

CLEMENT CARDON

SALESMAN

Office

Address

2

CARDON

3-50-1883

SALESMAN

SALESMAN

Mrs. Julia L. Cardon #2

RECEIVED

RECEIVED

3-50-1883

SALESMAN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G292 8/11/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

08716

2722

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>AA</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>AA</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>238 N. Hammonds Ferry Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Myrtle</u> Middle <u>William</u> Last <u>Chaney</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>4</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 4 - 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H W</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>AA County - Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>Wm Randolph Ray</u>		14. MOTHER'S MAIDEN NAME <u>Rachael M. Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Louise Humphrey - Glenburnie</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>443X</u> (b) <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 yrs</u> <u>5-6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1940 to 8/04</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>8/04/61</u> , 19 <u>61</u> , and that death occurred at <u>7:10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas. L. Ball Jr.</u>		ADDRESS (Street, city or town, state) <u>203 W. Maple Rd.</u> DATE SIGNED <u>8/04/61</u>	
PHYSICIAN'S NAME (Type) <u>Chas. L. Ball Jr.</u>		<u>Linthicum Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-8-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert P. Ware</u>		24a. REC'D BY REGISTRAR <u>AUG 9 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filled with the information requested. Page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the information requested prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		AGE	
SEX		RACE	
BIRTH DATE		BIRTH PLACE	
MARRIAGE DATE		MARRIAGE PLACE	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		SIGNATURE OF PHYSICIAN	
SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS	
DATE OF REGISTRATION		PLACE OF REGISTRATION	
SIGNATURE OF DEPUTY REGISTRAR		SIGNATURE OF WITNESS	
DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		AGE	
SEX		RACE	
BIRTH DATE		BIRTH PLACE	
MARRIAGE DATE		MARRIAGE PLACE	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		SIGNATURE OF PHYSICIAN	
SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS	
DATE OF REGISTRATION		PLACE OF REGISTRATION	
SIGNATURE OF DEPUTY REGISTRAR		SIGNATURE OF WITNESS	

104

Reg. Dist. No.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be completed in by the attending physician and be signed by the funeral director. This certificate has been signed by the attending physician and the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
8724												
CERTIFICATE OF DEATH												
08718												
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 535 Horn Point Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Linnie First Middle Last CLARK						4. DATE OF DEATH Month Day Year August 4 1961						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 1, 1885		9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME CHARLES HABERSANK						14. MOTHER'S MAIDEN NAME KATHERINE HIGH						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO						16. SOCIAL SECURITY NO. -		17. INFORMANT Linwood L. Clark		Address (2)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease DUE TO (b) Generalized arteriosclerosis DUE TO (c) Generalized arteriosclerosis CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) INTERVAL BETWEEN ONSET AND DEATH Instant												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		20g. (County) Md		20h. (State) Md	
21. I certify that (I) (the physician) attended the deceased from Aug 4 , 19 61 , to Aug 4 , 19 61 , that (I) (the) last saw the deceased alive on Aug 4 , 19 61 , and that death occurred at 3:15 A.M. from the causes and on the date stated above.												
22a. SIGNATURE Elmer G. Linhardt						M.D. Elmer G. Linhardt		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/4/61		
22c. PHYSICIAN'S NAME (Type) Elmer G. Linhardt						22d. ADDRESS 3 Chesapeake Ave., Annapolis, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-7-61		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City, town or county) Baltimore		23e. (State) Md		23f. (State) Md		
24. FUNERAL DIRECTOR'S SIGNATURE Gale M. Saylor Sins						ADDRESS Annapolis Md		25a. REC'D BY REGISTRAR DATE AUG 8 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Harris		

08218

1934



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Handwritten notes and stamps, including a date stamp "JAN 1 1934" and various illegible markings.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be completed by the attending physician and filed in the funeral home. Pages 3 and 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and is complete. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is complete. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
8725														
CERTIFICATE OF DEATH														
08719														
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>					c. LENGTH OF STAY IN 1b <u>51 days</u>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL - Crownsville</u>									
d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Marvin</u> Middle <u>Lee</u> Last <u>COALE</u>					4. DATE OF DEATH Month <u>August</u> Day <u>27</u> Year <u>19 61.</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 7, 1961</u>		9. AGE (In years last birthday) <u>1</u> yrs. <u>21</u> Months <u>1</u> Days <u>21</u> Hours <u></u> Min. <u></u>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				
13. FATHER'S NAME <u>Maurice Francis COALE</u>					14. MOTHER'S MAIDEN NAME <u>Sharon Marie MASTIN</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. (If yes, give number and date of service)					17. INFORMANT <u>Hospital Records</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>752X</u> DUE TO <u>Congenital hydrocephalus</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (c), stating the underlying cause last. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>19</u> p.m. <u></u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) <u>July 7, 1961</u>					20g. (County) <u>Aug. 27, 1961</u>					20h. (State) <u>1961</u>				
21. I certify that (I) <u>(not known)</u> attended the deceased from <u>July 7, 1961</u> to <u>Aug. 27, 1961</u> that (I) <u>was</u> last saw the deceased alive on <u>Aug. 27, 1961</u> and that death occurred at <u>9:15 P.M.</u> from the causes and on the date stated above.														
22a. SIGNATURE <u>Niel H. Sims</u>					22b. DATE <u>8/29/61</u>					22c. PHYSICIAN'S NAME (Type) <u>Niel H. Sims</u>				
22d. ADDRESS <u>95 Cathedral St., Annapolis, Md.</u>					22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>Aug. 29, 1961</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>				
23d. LOCATION (City, town or county) <u>Annapolis, Maryland</u>					23e. REC'D BY REGISTRAR <u>AUG 30 '61</u>					23f. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>					24a. ADDRESS <u>Annapolis, Md.</u>									

VR A15 (4)
15M 9/60

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Fragment of the original

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8726

08720

1. PLACE OF DEATH e. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institutions: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 4 yrs. 16 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS 835 Vine Street	
3. NAME OF DECEASED (Type or print) First John Middle Coates Last Coates		4. DATE OF DEATH Month 8 Day 15 Year 19 61	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1887
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 74 Days 15	IF UNDER 24 HRS. Hours 19 Min. 61
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (County & State, or foreign country) South Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Calvin ?	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes give year or dates of service)	
16. SOCIAL SECURITY NO. 218-10-5181		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Brain Disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour e.m. ----- p.m. 19	20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) -----
21. I certify that (I) (this hospital) attended the deceased from 7/29 , 19 57 , to 8/15/ , 19 61 , that (I) (we) last saw the deceased alive on 8/15 , 19 61 , and that death occurred at 11:40 , from the causes and on the date stated above.		22a. SIGNATURE L. Benedict, M. D.	
22b. DATE SIGNED 8/15/61		22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THROF 8/21/61	
23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		23d. LOCATION (City, town or county) (State) Balt. Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Halsband		25a. REC'D BY REGISTRAR DATE AUG 17 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hines		25c. ADDRESS 718 Druid Hill	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove call papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

(I)

2726

Anne Arnold

Crownsville

Crownsville State Hospital

John

Male

Married

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Canton

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South Carolina

U.S.A.

Laborer

Galvan

Unknown

218-10-2101

Hospital Record

Chromophanoma

1 week

Spinal cord disease

61

1912

W

V. 2

11:40

61

8/12

8/12/21

Dr. J. B. ...

Crownsville State Hospital, Maryland

Dr. J. B. ...

Dr. J. B. ...

Dr. J. B. ...

Dr. J. B. ...

8727

CERTIFICATE OF DEATH

Reg. Dist. No.

08721

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>X</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shenandoah</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>915 Steward Ave</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Sarah Bell</u> First Middle Last		4. DATE OF DEATH <u>Aug</u> Month <u>19</u> Day <u>1961</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25 1877</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AA Co. Md.</u>	11. BIRTHPLACE (State or foreign country) <u>AA Co. Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>—</u>		13. FATHER'S NAME <u>Francis Bell</u>	
14. MOTHER'S MAIDEN NAME <u>Wester Cheney</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Margaret Dicus</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-vascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2-3 yr</u> <u>10-12 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1952</u> to <u>8/19/61</u> that I last saw the deceased alive on <u>8/19/61</u> , 19 <u>61</u> , and that death occurred on <u>12:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas L. Ball</u> M.D.		ADDRESS (Street, city or town, state) <u>203 W. Maple Rd - 8/19/61</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Charles L. Ball, M.D.</u>		<u>Linthicum Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/22/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baldwin Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Millersville, AA Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley</u> ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 22 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

00734

RECORDS BOARD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased is in the hospital or attending physician, the law requires that the death certificate be executed within 24 hours after death. If the deceased is in the hospital or attending physician, the law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 82 Cathedral St.	
3. NAME OF DECEASED (Type or print) First Rachal Middle DUVALL Last DUVALL		4. DATE OF DEATH Month August Day 29 Year 19 61	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1893
9. AGE (In years last birthday) 67 1/2 yrs.		10. IF UNDER 1 YEAR Months 6 Days 18	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic - Cook		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME James Brown		14. MOTHER'S MAIDEN NAME Harriett ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Alexina Thomas - Rt. 2-Box 462 Anna. Md.	
17. INFORMANT Alexina Thomas - Rt. 2-Box 462 Anna. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 443X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Cardiovascular accident by pericardial effusion Post operative patient 4 days			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) Dr. Stuart M. Christhilf attended the deceased from Aug. 29, 1961 to Aug. 29, 1961 that (I) see last saw the deceased alive on Aug. 29, 1961 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. Stuart M. Christhilf		22b. DATE SIGNED 8/30/61	
22c. PHYSICIAN'S NAME (Type) Dr. Stuart M. Christhilf		22d. ADDRESS 69 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 1-61	
23c. NAME OF CEMETERY OR CREMATORY Broadneck		23d. LOCATION (City, town or county) (State) A.A.Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE C.E.Hicks 111		25. REGISTRAR'S SIGNATURE Arthur S. Thomas	
25a. REC'D BY REGISTRAR SEP 6 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

may be filled by the attending physician and completed after the funeral director has been signed by the funeral director. After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8729

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08723

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade				c. LENGTH OF STAY IN 1b -			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KIMBROUGH ARMY HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First - Middle - Last FARQUHAR				4. DATE OF DEATH Month AUGUST Day 24 Year 19 61			
5. SEX Male		6. COLOR OR RACE Cau		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 24 Aug 61	
9. AGE (In years last birthday) yrs. 25		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -				10b. KIND OF BUSINESS OR INDUSTRY -			
13. FATHER'S NAME Richard Farquhar				14. MOTHER'S MAIDEN NAME Nancy Tomlinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Mother-4319 Allen Dr Balto, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalic DUE TO 751X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Spina bifida DUE TO (c) at birth							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the deceased) attended the deceased from 24 Aug 19 61 to 24 Aug 19 61 that (I) (we) last saw the deceased alive on 24 Aug 19 61 and that death occurred at 11:05 A from the causes and on the date stated above.							
22a. SIGNATURE Stuart Bernstein Capt MC				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 24 Aug 61	
22c. PHYSICIAN'S NAME (Type) STUART M. BERNSTEIN, Capt., M.C.				22d. ADDRESS Kimbrough AH Ft Geo G. Meade, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) 19 Aug 61		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE William J Steyer M.F. Harry Hest				ADDRESS Kimbrough		25a. REC'D BY REGISTRAR DATE AUG 31 61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

2050221 XV2

(M)

(C)

(D)



1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the Director, who may extend the time. Give the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8730 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08724											
1. PLACE OF DEATH a. COUNTY Anne Arundel						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Same b. COUNTY Same					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Severn				c. LENGTH OF STAY IN 1b 17 y.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Same				d. STREET ADDRESS Same	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Box 198 Route 3						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Joseph Edward Foster						4. DATE OF DEATH Aug. 15th 19 61					
5. SEX M		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/13/11		9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Furnace operator				10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Edward Joseph Foster						14. MOTHER'S MAIDEN NAME Anna Hampschuh					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. Jimmie Foster (son)		17. INFORMANT Address Jimmie Foster (son)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Self inflicted wound to the heart with a 16 gauge DUE TO (b) shot gun. DUE TO (c) Sudden											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) As per #18							
20c. TIME OF INJURY Month, Day, Year Found dead at 12.50 p.m. 8/15/61 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Basement, at home, Severn A.A. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Gustave H. Faubert, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 8/16/61			
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) Glen Burnie, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 8/18/61		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem.		22d. LOCATION (City, town, or county) (State) Glen Burnie, Md			
23. FUNERAL DIRECTOR Hopping & KIRKLEY						ADDRESS Glen Burnie		24a. REC'D BY REGISTRAR AUG 21 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

NO. 1000
1000



1. NAME (Last, First, Middle Initial) _____

2. DATE OF BIRTH (Month, Day, Year) _____

3. SEX (Male, Female) _____

4. RACE (White, Negro, Other) _____

5. HEIGHT (Feet, Inches) _____

6. WEIGHT (Pounds) _____

7. BLOOD PRESSURE (Systolic, Diastolic) _____

8. TEMPERATURE (Fahrenheit) _____

9. PULSE (Per Minute) _____

10. RESPIRATION (Per Minute) _____

11. HEART (Normal, Abnormal) _____

12. LUNGS (Normal, Abnormal) _____

13. STOMACH (Normal, Abnormal) _____

14. SMALL INTESTINE (Normal, Abnormal) _____

15. LARGE INTESTINE (Normal, Abnormal) _____

16. BLADDER (Normal, Abnormal) _____

17. KIDNEYS (Normal, Abnormal) _____

18. SPLEEN (Normal, Abnormal) _____

19. PANCREAS (Normal, Abnormal) _____

20. LIVER (Normal, Abnormal) _____

21. GALLBLADDER (Normal, Abnormal) _____

22. THYROID (Normal, Abnormal) _____

23. PARATHYROID (Normal, Abnormal) _____

24. ADRENAL (Normal, Abnormal) _____

25. PITUITARY (Normal, Abnormal) _____

26. HYPOTHALAMUS (Normal, Abnormal) _____

27. HYPOPHYSIS (Normal, Abnormal) _____

28. EPITHELIUM (Normal, Abnormal) _____

29. CONNECTIVE TISSUE (Normal, Abnormal) _____

30. MUSCLES (Normal, Abnormal) _____

31. BONES (Normal, Abnormal) _____

32. SKIN (Normal, Abnormal) _____

33. NAILS (Normal, Abnormal) _____

34. HAIR (Normal, Abnormal) _____

35. EYES (Normal, Abnormal) _____

36. EARS (Normal, Abnormal) _____

37. NOSE (Normal, Abnormal) _____

38. MOUTH (Normal, Abnormal) _____

39. THROAT (Normal, Abnormal) _____

40. LARYNX (Normal, Abnormal) _____

41. TRACHEA (Normal, Abnormal) _____

42. BRONCHI (Normal, Abnormal) _____

43. LUNGS (Normal, Abnormal) _____

44. PLEURA (Normal, Abnormal) _____

45. PERITONEUM (Normal, Abnormal) _____

46. PERICARDIUM (Normal, Abnormal) _____

47. ENDOMETRIUM (Normal, Abnormal) _____

48. VAGINA (Normal, Abnormal) _____

49. UTERUS (Normal, Abnormal) _____

50. OVARY (Normal, Abnormal) _____

51. TUBES (Normal, Abnormal) _____

52. VULVA (Normal, Abnormal) _____

53. CLITORIS (Normal, Abnormal) _____

54. PENIS (Normal, Abnormal) _____

55. TESTES (Normal, Abnormal) _____

56. EPIDIDYMIS (Normal, Abnormal) _____

57. VAS DEFERENS (Normal, Abnormal) _____

58. SEMINAL VESICLE (Normal, Abnormal) _____

59. PROSTATE (Normal, Abnormal) _____

60. URETHRA (Normal, Abnormal) _____

61. BLADDER (Normal, Abnormal) _____

62. RECTUM (Normal, Abnormal) _____

63. SIGMOID (Normal, Abnormal) _____

64. CECUM (Normal, Abnormal) _____

65. ILEUM (Normal, Abnormal) _____

66. JEJUNUM (Normal, Abnormal) _____

67. DUODENUM (Normal, Abnormal) _____

68. PANCREAS (Normal, Abnormal) _____

69. GALLBLADDER (Normal, Abnormal) _____

70. LIVER (Normal, Abnormal) _____

71. SPLEEN (Normal, Abnormal) _____

72. THYROID (Normal, Abnormal) _____

73. PARATHYROID (Normal, Abnormal) _____

74. ADRENAL (Normal, Abnormal) _____

75. PITUITARY (Normal, Abnormal) _____

76. HYPOTHALAMUS (Normal, Abnormal) _____

77. HYPOPHYSIS (Normal, Abnormal) _____

78. EPITHELIUM (Normal, Abnormal) _____

79. CONNECTIVE TISSUE (Normal, Abnormal) _____

80. MUSCLES (Normal, Abnormal) _____

81. BONES (Normal, Abnormal) _____

82. SKIN (Normal, Abnormal) _____

83. NAILS (Normal, Abnormal) _____

84. HAIR (Normal, Abnormal) _____

85. EYES (Normal, Abnormal) _____

86. EARS (Normal, Abnormal) _____

87. NOSE (Normal, Abnormal) _____

88. MOUTH (Normal, Abnormal) _____

89. THROAT (Normal, Abnormal) _____

90. LARYNX (Normal, Abnormal) _____

91. TRACHEA (Normal, Abnormal) _____

92. BRONCHI (Normal, Abnormal) _____

93. LUNGS (Normal, Abnormal) _____

94. PLEURA (Normal, Abnormal) _____

95. PERITONEUM (Normal, Abnormal) _____

96. PERICARDIUM (Normal, Abnormal) _____

97. ENDOMETRIUM (Normal, Abnormal) _____

98. VAGINA (Normal, Abnormal) _____

99. UTERUS (Normal, Abnormal) _____

100. OVARY (Normal, Abnormal) _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
8731														
CERTIFICATE OF DEATH														
Item 8 Film G293 8/21/61 mh														
08725														
1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CROWNSVILLE					c. LENGTH OF STAY IN 1b 2 mo. 6 days									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) CROWNSVILLE STATE HOSPITAL					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3 V01-4									
d. STREET ADDRESS 1617 WESTWOOD AVE.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First LOUISE Middle M. Last FREELAND					4. DATE OF DEATH Month 8 Day 20 Year 1961									
5. SEX FEMALE		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/29/1886		9. AGE (In years last birthday) 75 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) ?		12. CITIZEN OF WHAT COUNTRY? U.S.A.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						
13. FATHER'S NAME ?					14. MOTHER'S MAIDEN NAME MARY A. SMOCK									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO. -					17. INFORMANT Address Dr. I. Turek CROWNSVILLE STATE HOSP.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pylonephritis DUE TO (b) Nephrolithiasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) -----									
20c. TIME OF INJURY Month, Day, Year Hour a.m. ----- p.m. 19			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 6/14 , 1961 , to 8/20 , 1961 , that (I) (we) last saw the deceased alive on 8/20 , 1961 and that death occurred at 1 AM , from the causes and on the date stated above.														
22a. SIGNATURE [Signature]					22b. DATE 8/21/61									
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.					22d. ADDRESS Crownsville State Hospital, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Journal			23b. DATE THEREOF 8-24-61		23c. NAME OF CEMETERY OR CREMATORY arbitus		23d. LOCATION (City, town or county) (State) md							
24. GENERAL DIRECTOR'S SIGNATURE [Signature]					25a. REC'D BY REGISTRAR DATE AUG 22 '61					25b. REGISTRAR'S SIGNATURE Arthur S. Knauf				

0257-9546/98/0005-0000\$05.00/0

1. *Journal of the American Medical Association*, 1997; 278: 1023-1028.

TO DEPUTY MEDICAL EXAMINER: This certificate must be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar, and to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8732

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08726

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Me.</u> b. COUNTY <u>aa</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundicksonville</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
				d. STREET ADDRESS <u>1213 McRunley St</u>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Burgess</u> Last <u>French</u>				4. DATE OF DEATH Month <u>8</u> Day <u>4</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-13-1925</u>	
9. AGE (In years last birthday) <u>36</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Truck Driver</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Shelma Wells</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>W. W. II</u>				16. SOCIAL SECURITY NO. <u>219-16-0577</u>		17. INFORMANT <u>EVELYN M. FRENCH</u> Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon Monoxide (asphyxia)</u> 973.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-10-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Orlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Orlington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jahm M. Taylor</u>				24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	
				DATE <u>AUG 11 '61</u>			

MEDICAL CERTIFICATION

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Sex: ☐ Male ☐ Female

3. Age: _____

4. Date of Death: _____

5. Place of Death: _____

6. Cause of Death: _____

7. Manner of Death: ☐ Natural ☐ Accidental ☐ Suicidal ☐ Homicidal

8. Signature of Medical Examiner: _____

9. Date of Examination: _____

10. Signature of Registrar: _____

11. Date of Registration: _____

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. This certificate should be used as a burial-transit permit. File pages 1 and 2 with the registrar, and to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8733 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 118727

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <u>Ill</u> b. COUNTY <u>Cook</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN Ill <u>SIX-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A. A. GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>5351 N. Paulina St</u>	
3. NAME OF DECEASED (Type or print) First <u>Natalie</u> Middle <u>Frykendale</u> Last <u></u>		4. DATE OF DEATH Month <u>8-</u> Day <u>11</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 25th 1889</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frans Peterson</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Reinhold Johnson</u>		Address <u>7065 Kenney St Niles 48 Ill.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.4</u> DUE TO <u>Stroke</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>Stroke</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhart</u>		DATE SIGNED <u>8/11/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-16-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Annnapolis Mpl.</u>		22d. LOCATION (City, town, or county) (State) <u>CHICAGO</u> <u>ILL.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		24a. RECEIVED BY REGISTRAR <u>Aug 16 61</u>	
ADDRESS <u>Annnapolis Mpl.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krueger</u>	

NAVY AND MARINE CORPS DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Service Number: _____

3. Date of Death: _____

4. Place of Death: _____

5. Cause of Death: _____

6. Manner of Death: _____

7. Signature of Medical Examiner: _____

8. Signature of Reporting Officer: _____

9. Signature of Coroner: _____

10. Signature of Burial Officer: _____

11. Signature of Witness: _____

12. Signature of Physician: _____

13. Signature of Nurse: _____

14. Signature of Chaplain: _____

15. Signature of Other: _____

16. Signature of Other: _____

17. Signature of Other: _____

18. Signature of Other: _____

19. Signature of Other: _____

20. Signature of Other: _____

21. Signature of Other: _____

22. Signature of Other: _____

23. Signature of Other: _____

24. Signature of Other: _____

25. Signature of Other: _____

26. Signature of Other: _____

27. Signature of Other: _____

28. Signature of Other: _____

29. Signature of Other: _____

30. Signature of Other: _____

31. Signature of Other: _____

32. Signature of Other: _____

33. Signature of Other: _____

34. Signature of Other: _____

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99. Signature of Other: _____

100. Signature of Other: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 7 Film G292 8/15/61 ink

8734

108728

1. PLACE OF DEATH a. COUNTY A A b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST MARGARETS c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY A A c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST MARGARETS d. STREET ADDRESS R.T.D ANNAPOLIS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THOMAS Middle OWEN Last GAMBLE		4. DATE OF DEATH Month 8 Day 7 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 11th 1890
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 7 Days 19	IF UNDER 24 HRS. Hours 11 Min. 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHYSICIAN		10b. KIND OF BUSINESS OR INDUSTRY PHYSICIAN	
11. BIRTHPLACE (State or foreign country) ALABAMA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME FRANKLIN A. GAMBLE		14. MOTHER'S MAIDEN NAME MARY OWEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT ISABEL D. GAMBLE		Address # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Oat Cell Carcinoma of lung 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 162.1 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilob. Bronchiectasis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bridge, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 19 to Aug 7 , 19 61 , that (I) (we) last saw the deceased alive on 8-7-1961 , and that death occurred 8-8-61 from the causes and on the date stated above.			
22a. SIGNATURE Frank M. Shipley		22b. DATE SIGNED 8-8-61	
22c. PHYSICIAN'S NAME (Type) FRANK M. SHIPLEY		22d. ADDRESS Annapolis, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-10-61	
23c. NAME OF CEMETERY OR CREMATORY St Margarets Cem		23d. LOCATION (City, town, or county) (State) St Margarets Md	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor		25. REC'D BY REGISTRAR Aug 11 '61	
26. REGISTRAR'S SIGNATURE Arthur S. Thomas			

10738

CERTIFICATE OF DEATH

10738



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08729

8735

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burne</u>				c. LENGTH OF STAY IN 1b <u>3 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3 V 01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>124 Wilson Blvd.</u>				d. STREET ADDRESS <u>1231 Hull St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Grace</u> First <u>ELIZABETH</u> Middle <u>GERTZ</u> Last				4. DATE OF DEATH Month <u>8-</u> Day <u>22</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 22, 1900</u>		9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Maher</u>				14. MOTHER'S MAIDEN NAME <u>Grace Wasmus</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-30-7931</u>		17. INFORMANT <u>Helen Zetz 124 Wilson</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>155-1</u> IMMEDIATE CAUSE (a) <u>CARCINOMA LEFT HEPATIC DUCT</u> DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u> DUE TO (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 MONTHS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> 19 <u>61</u> to <u>August</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8-21</u> 19 <u>61</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>C. MacDonald M.D.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8-22-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>204 Plain Mary, Glen Burnie Md</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-25-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery Baltimore Md.</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. Stevens Funeral Home, Inc.</u>				ADDRESS <u>1501 E. Fort Ave.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 25 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>			

BP

15533

CRIMINAL RECORDS

15533

(M)

(1)

(C)

CRIMINAL RECORDS

1 FOR STATE HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 must be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 8736 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08730

1. PLACE OF DEATH e. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY in lb 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Crownsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS B 60 Ranch		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ralph Middle GREER Last GREER				4. DATE OF DEATH Month August Day 9 Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 3, 1913		9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months 48 Days 48	IF UNDER 24 HRS. Hours 48 Min. 48
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal miner		10b. KIND OF BUSINESS OR INDUSTRY Coal		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Robert Greer				14. MOTHER'S MAIDEN NAME Mary Coughton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 235-07-5690		17. INFORMANT Hospital records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia, bilateral DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>[Signature]</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) F. L. Linhart				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Annapolis, Md.				DATE SIGNED 8/10/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial		22b. DATE THEREOF Aug. 10, 61		22c. NAME OF CEMETERY OR CREMATORY Wallace Memorial Cemetery		22d. LOCATION (City, town, or country) (State) Clintonville, Vest Va.	
23. FUNERAL DIRECTOR Hopping Funeral Home				ADDRESS Annapolis, Maryland			
24a. REC'D BY REGISTRAR DATE AUG 14 '61				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

MEDICAL CERTIFICATION

1
FOR STATE
HEALTH DEPT.

(M)

(I)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8737 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08731

1. PLACE OF DEATH a. COUNTY Anne Arundle MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Anne Arundle			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b Lathion		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lathion		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundle General				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Floyd Middle - Last Griffin				4. DATE OF DEATH Month August Day 27 Year 1961			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3-8-1960	9. AGE (In years last birthday) 15 mos.	IF UNDER 1 YEAR Months 15 Days 00		IF UNDER 24 HRS. Hours 00 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Griffin				14. MOTHER'S MARRIED NAME Helen Stood			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 111-11-1111		17. INFORMANT Address Helen Griffin Lathion, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aspiration of stomach content DUE TO (c) Gastro - entero - colitis						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Russell S. Fisher		M.D. Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8/28/61	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		ADDRESS (Street, city, town, or county)		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF 8-21-61		22c. NAME OF CEMETERY OR CREMATORY Moses		22d. LOCATION (City, town, or country) (State) Drewery, Md.			
23. FUNERAL DIRECTOR William Beese, Jr. - Annapolis, Md.		ADDRESS		24a. REC'D BY REGISTRAR AUG 29 '61		24b. REGISTRAR'S SIGNATURE William S. Fisher	

HEALTH UNIT

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(9)

(10)

2337 MEDICAL EXAMINATION CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES OF AMERICA

THIS CERTIFICATE IS TO BE FILLED OUT BY A PHYSICIAN OR OTHER PERSON QUALIFIED TO MAKE SUCH EXAMINATION.

1. NAME OF DECEASED: *John Doe*

2. SEX: *Male*

3. AGE: *65*

4. DATE OF DEATH: *10/15/1964*

5. PLACE OF DEATH: *Home*

6. CAUSE OF DEATH: *Myocardial Infarction*

7. MANNER OF DEATH: *Natural*

8. SIGNATURE OF PHYSICIAN: *John Doe*

9. SIGNATURE OF DECEASED: *John Doe*

10. SIGNATURE OF WITNESS: *John Doe*

11. SIGNATURE OF DECEASED: *John Doe*

12. SIGNATURE OF WITNESS: *John Doe*

13. SIGNATURE OF DECEASED: *John Doe*

14. SIGNATURE OF WITNESS: *John Doe*

15. SIGNATURE OF DECEASED: *John Doe*

16. SIGNATURE OF WITNESS: *John Doe*

17. SIGNATURE OF DECEASED: *John Doe*

18. SIGNATURE OF WITNESS: *John Doe*

19. SIGNATURE OF DECEASED: *John Doe*

20. SIGNATURE OF WITNESS: *John Doe*

21. SIGNATURE OF DECEASED: *John Doe*

22. SIGNATURE OF WITNESS: *John Doe*

23. SIGNATURE OF DECEASED: *John Doe*

24. SIGNATURE OF WITNESS: *John Doe*

25. SIGNATURE OF DECEASED: *John Doe*

26. SIGNATURE OF WITNESS: *John Doe*

27. SIGNATURE OF DECEASED: *John Doe*

28. SIGNATURE OF WITNESS: *John Doe*

29. SIGNATURE OF DECEASED: *John Doe*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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8738
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08732

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gambrells</u>				c. LENGTH OF STAY IN 1b <u>93 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAIRVIEW</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>Gladys</u> Last <u>HAMMOND</u>				4. DATE OF DEATH Month <u>August</u> Day <u>6</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 27, 1867</u>	
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>J. LACKLAND HIGGINS</u>				14. MOTHER'S MAIDEN NAME <u>MARY A. HAMMOND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>MRS DALLAS HIGGINS, SAME AS 2</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Accident</u> 4432x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vascular Disease</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1946</u> to <u>Aug 6</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Aug 5</u> , 19 <u>61</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Edward G. Skovitt</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Aug 7, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward G. Skovitt M.D.</u>				22d. ADDRESS <u>Gambrells Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/8/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Waugh Chapel</u>		23d. LOCATION (City, town, or county) (State) <u>Gambrells Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping & KRAUSE, Glen Burnie</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 11 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8739
CERTIFICATE OF DEATH
08733

1. PLACE OF DEATH a. COUNTY <i>Al.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Al.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arundel on the Bay</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arundel on the Bay</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cohasset Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Minnie L. Heintz</i>		4. DATE OF DEATH Month <i>8</i> - Day <i>13</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 20-1872</i>
9. AGE (In years lost birthday) <i>89</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Evansston Ill</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Jacob Rinn</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Caroline M. Heintz</i> Address <i>(2)</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>592X Azotemia</i> DUE TO <i>Chronic Nephritis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>2 yrs.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>JAN 1, 1908</i> to <i>8-12-1961</i> , that (I) (we) last saw the deceased alive on <i>8-12-1961</i> , and that death occurred at <i>5:00 P</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>James R. Martin</i>		22b. DATE SIGNED <i>8-14-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>JAMES R. MARTIN</i>		22d. ADDRESS <i>6 SHAW ST. ANNAPOLIS, MD.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8-15-1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>St Annies Cemt.</i>		23d. LOCATION (City, town, or county) (State) <i>Annapolis Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Saylor</i>		25a. REGISTRAR'S SIGNATURE <i>Arthur L. Harned</i>	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	

1914

(1)

WELLS FARGO BANK
CLEARING ACCOUNT
1914

(2)

WELLS FARGO BANK
CLEARING ACCOUNT
1914

1914

1914

1914

1914

1914

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8740

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08734

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>X</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Anne Arundel General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>MICHAEL</u> Last <u>HITTLE</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>5</u> Year <u>19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 11, 1957</u>
9. AGE (in years last birthday) <u>3</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Paul A. Hittle</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Cole</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr. Paul A. Hittle - Father-</u>		Address <u>same as # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACCIDENTAL DROWNING</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>929.8</u> (c), stating the underlying cause lost. DUE TO <u>929.8</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drowned in pond on Farm</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>0800</u> <u>Aug 5,</u> 19 <u>61</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Pond on farm</u>	
20f. (City or town) <u>Gambrills, A.A., Maryland</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Elmer G. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Elmer G. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>August 5, 1961</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>August 7, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Our Lady of Sorrows</u>		22d. LOCATION (City, town, or county) (State) <u>Owensville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		ADDRESS <u>Annapolis, Maryland</u>	
24a. REC'D BY REGISTRAR <u>DATE AUG 8 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF VITAL RECORDS		20. SIGNATURE OF HEALTH DEPARTMENT		21. SIGNATURE OF STATE DEPARTMENT	
22. SIGNATURE OF COUNTY CLERK		23. SIGNATURE OF TOWN CLERK		24. SIGNATURE OF VOTING CLERK	
25. SIGNATURE OF SCHOOL CLERK		26. SIGNATURE OF CHURCH CLERK		27. SIGNATURE OF POST OFFICE CLERK	
28. SIGNATURE OF COURT CLERK		29. SIGNATURE OF PROBATE CLERK		30. SIGNATURE OF LAND RECORDS CLERK	
31. SIGNATURE OF TAX CLERK		32. SIGNATURE OF RECORDS CLERK		33. SIGNATURE OF COMMISSIONER	
34. SIGNATURE OF ATTORNEY GENERAL		35. SIGNATURE OF JUDGE		36. SIGNATURE OF CLERK	
37. SIGNATURE OF SHERIFF		38. SIGNATURE OF CONSTABLE		39. SIGNATURE OF TOWNSMAN	
40. SIGNATURE OF VOTER		41. SIGNATURE OF ELECTION CLERK		42. SIGNATURE OF JURY	
43. SIGNATURE OF WITNESSES		44. SIGNATURE OF FUNERAL HOME		45. SIGNATURE OF BURIAL PLACE	
46. SIGNATURE OF VITAL RECORDS		47. SIGNATURE OF HEALTH DEPARTMENT		48. SIGNATURE OF STATE DEPARTMENT	
49. SIGNATURE OF COUNTY CLERK		50. SIGNATURE OF TOWN CLERK		51. SIGNATURE OF VOTING CLERK	
52. SIGNATURE OF SCHOOL CLERK		53. SIGNATURE OF CHURCH CLERK		54. SIGNATURE OF POST OFFICE CLERK	
55. SIGNATURE OF COURT CLERK		56. SIGNATURE OF PROBATE CLERK		57. SIGNATURE OF LAND RECORDS CLERK	
58. SIGNATURE OF TAX CLERK		59. SIGNATURE OF RECORDS CLERK		60. SIGNATURE OF COMMISSIONER	
61. SIGNATURE OF ATTORNEY GENERAL		62. SIGNATURE OF JUDGE		63. SIGNATURE OF CLERK	
64. SIGNATURE OF SHERIFF		65. SIGNATURE OF CONSTABLE		66. SIGNATURE OF TOWNSMAN	
67. SIGNATURE OF VOTER		68. SIGNATURE OF ELECTION CLERK		69. SIGNATURE OF JURY	
70. SIGNATURE OF WITNESSES		71. SIGNATURE OF FUNERAL HOME		72. SIGNATURE OF BURIAL PLACE	
73. SIGNATURE OF VITAL RECORDS		74. SIGNATURE OF HEALTH DEPARTMENT		75. SIGNATURE OF STATE DEPARTMENT	
76. SIGNATURE OF COUNTY CLERK		77. SIGNATURE OF TOWN CLERK		78. SIGNATURE OF VOTING CLERK	
79. SIGNATURE OF SCHOOL CLERK		80. SIGNATURE OF CHURCH CLERK		81. SIGNATURE OF POST OFFICE CLERK	
82. SIGNATURE OF COURT CLERK		83. SIGNATURE OF PROBATE CLERK		84. SIGNATURE OF LAND RECORDS CLERK	
85. SIGNATURE OF TAX CLERK		86. SIGNATURE OF RECORDS CLERK		87. SIGNATURE OF COMMISSIONER	
88. SIGNATURE OF ATTORNEY GENERAL		89. SIGNATURE OF JUDGE		90. SIGNATURE OF CLERK	
91. SIGNATURE OF SHERIFF		92. SIGNATURE OF CONSTABLE		93. SIGNATURE OF TOWNSMAN	
94. SIGNATURE OF VOTER		95. SIGNATURE OF ELECTION CLERK		96. SIGNATURE OF JURY	
97. SIGNATURE OF WITNESSES		98. SIGNATURE OF FUNERAL HOME		99. SIGNATURE OF BURIAL PLACE	
100. SIGNATURE OF VITAL RECORDS		101. SIGNATURE OF HEALTH DEPARTMENT		102. SIGNATURE OF STATE DEPARTMENT	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 must be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8741 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
08735											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>—</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANN ARUNDIS</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>					
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>						d. STREET ADDRESS <u>6309 FAIT AVE</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ANNE ARUNDEL GENERAL HOSP.</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Henry Hopkins</u>						4. DATE OF DEATH Month <u>8</u> Day <u>24</u> Year <u>1961</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/29/05</u>		9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN; REID-AVERY CO.</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>					
11. BIRTHPLACE (State or foreign country) <u>MD.</u>						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>JOHN HOPKINS</u>						14. MOTHER'S MAIDEN NAME <u>ELIZABETH LENTZ</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>214-05-3963</u>					
17. INFORMANT <u>MATILDA HOPKINS</u>						Address <u>6309 FAIT AVE.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary occlusion</u> DUE TO (b) <u>hypertension -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Emily H. Wilson</u>						DATE SIGNED <u>8/24/61</u>					
EXAMINER'S NAME (Type) <u>EMILY H. WILSON</u>						DEPUTY MEDICAL EXAMINER <u>—</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>						22b. DATE THEREOF <u>8/28/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		22d. LOCATION (City, town, or country) (State) <u>BALTO. CO. MD.</u>	
23. FUNERAL DIRECTOR <u>SW. Hoffmann</u>						ADDRESS <u>3218 HUDSON ST.</u>					
24a. REC'D BY REGISTRAR <u>—</u>						24b. REGISTRAR'S SIGNATURE <u>—</u>					
DATE <u>AUG 28 '61</u>						—					

BP

100-1000

(M)

100-1000

THE BOARD OF DIRECTORS
OF THE
AMERICAN
ASSOCIATION
OF
NATIVE
AMERICAN
BUSINESS
MEN

JOHN HARRIS
ELIZABETH HARRIS
AND
THEIR
CHILDREN

THE
HARRIS
FAMILY

THE
HARRIS
FAMILY

THE
HARRIS
FAMILY

CERTIFICATE OF DEATH

Reg. Dist. No.

18736

8742

1. PLACE OF DEATH a. COUNTY <u>A.A.C.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>Richmond</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HANOVER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Richmond</u>	
c. LENGTH OF STAY IN 1b <u>Days</u>		d. STREET ADDRESS <u>6800 Linbrook Dr</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Esther Penrott Hyatt</u>		4. DATE OF DEATH Month <u>August</u> Day <u>14</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24, 1886</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u> Hours <u>14</u> Min. <u>19</u>	11. IF UNDER 24 HRS. Months <u>7</u> Days <u>14</u> Hours <u>14</u> Min. <u>19</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>	
INFORMANT <u>Ralph E Hyatt - 6800 Linbrook Drive</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vasular Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerotic Vascular Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>August 14, 1961</u> , to <u>August 14, 1961</u> , that I last saw the deceased alive on <u>August 14, 1961</u> , and that death occurred at <u>11:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. Rodenick Shipley</u>		M.D. <u>524 Camp Meade Road</u>	
PHYSICIAN'S NAME (Type) <u>E. Rodenick Shipley</u>		ADDRESS (Street, city or town, state) <u>Leathicum Heights, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 16 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Richmond Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Richmond Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry C. Zink</u>		ADDRESS <u>5119 Burnside Rd</u>	
24a. REG'D BY REGISTRAR <u>AUG 16 1961</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10380

CERTIFICATE OF DEATH

188

MINI FILM



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8743

Item 9 Film G292 8/10/61 iwk

08737

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b Annapolis d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 1918 Park Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James T. IVEY		4. DATE OF DEATH August 1, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 26, 1882
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd U.S. Government Naval Academy		11b. KIND OF BUSINESS OR INDUSTRY Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Thomas Ivey	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 420-1		17. INFORMANT Helen J. Little Address (5)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac. Coronary Thrombosis DUE TO (b) Art. Cardiovascular Disease DUE TO (c) Comp. Fw. Heart Failure, G.I. Bleeding, origin unknown		INTERVAL BETWEEN ONSET AND DEATH Instantaneous	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21. TIME OF INJURY Month, Day, Year July 28, 1961		22. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 31 Southgate Ave., Annapolis, Md.	
23. CITY OR TOWN (City, town or county) Annapolis		24. STATE (State) Md	
25. I certify that (I) (If deceased) attended the deceased from July 28, 1961 to Aug. 1, 1961 , that (I) (If not) saw the deceased alive on Aug. 1, 1961 , and that death occurred at M , from the causes and on the date stated above.		26. SIGNATURE Dr. Maurice Klawans M.D. 3:20 P.M.	
27. PHYSICIAN'S NAME (Type) Dr. Maurice Klawans		28. ADDRESS 31 Southgate Ave., Annapolis, Md.	
29. BURIAL, CREMATION, REMOVAL (Specify) Burial		30. DATE THEREOF 8-4-1962	
31. NAME OF CEMETERY OR CREMATORY Cedar Bluff Court		32. LOCATION (City, town or county) Annapolis	
33. STATE (State) Md		34. REC'D BY REGISTRAR Arthur S. Kraus	
35. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sr.		36. REGISTRAR'S SIGNATURE Arthur S. Kraus	
37. ADDRESS Annapolis, Md		38. DATE AUG 7 '61	

(M)

(I)

(2)

Mr. J. H. [illegible]

Dear Sir: [illegible]
[illegible]
[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8744

18738

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN TB 25 years 11 mos. 13 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1400 McCulloh Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Edmund Jackson		4. DATE OF DEATH Month 8 Day 6 Year 1961					
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 1, 1925	9. AGE (In years last birthday) 35 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Jackson			14. MOTHER'S MAIDEN NAME Rebecca ?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 212-18-9159		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary TBo DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mongolism						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) -----	(County) -----	(State) -----		
21. I certify that (I) (this hospital) attended the deceased from 8/23 , 1937 to 8/6 , 1961 , that (I) (we) last saw the deceased alive on 8/6 , 1961 , and that death occurred at 7:25 P. , from the causes and on the date stated above.							
22a. SIGNATURE Lionel McHenry Mapp, M. D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/7/61			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Crownsville State Hospital, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-9-61	23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem		23d. LOCATION (City, town or county) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Mr. Francis W. Henney		ADDRESS 578 E. Biddle St.		25a. REC'D BY REGISTRAR AUG 10 '61	25b. REGISTRAR'S SIGNATURE Arthur L. Hume		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards, papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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References

Research

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Idonei McHenry Mapp, M.D.

Cromwell's State Hospital

8-9-8

Figure 1.11.11

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MARYLAND STATE DEPARTMENT OF HEALTH - BETHESDA, MD. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **08739**

8745

| | | | |
|---|-------------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY AA. CO.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
DO. A. HUNT ARCADE. 9th | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD
b. COUNTY AA. CO.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X Carluh Heights.
d. STREET ADDRESS
1
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
GEORGE DWINO JACKSON. | | 4. DATE OF DEATH
Month Day Year
8 11 1961 | |
| 5. SEX
F | 6. COLOR OR RACE
C | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1-18-20 |
| 9. AGE (In years last birthday)
41 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY
Domestic | |
| 11. BIRTHPLACE (State or foreign country)
Barclaysville A.A. | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
Chas. Abrams | | 14. MOTHER'S MAIDEN NAME
Georgianna Green | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
216-26-6526 | |
| 17. INFORMANT
George Green | | Address
Crownsville | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac
434.4 DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(a), stating the underlying cause lost. DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | |
| 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | |
| ACTUAL SIGNATURE
E. L. Linhorst | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type)
E. L. Linhorst | | DATE SIGNED
8/11/61 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Aug 14 1961 | | 22b. DATE THEREOF
Aug 14 1961 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Calverton's Hill | | 22d. LOCATION (City, town, or county) (State)
Jones Station Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Annie A. Johnson | | ADDRESS
Annapolis | |
| 24a. REG. DAY REGISTRAR
Aug 16 61 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. House | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar for burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|-------------------------------------|--|--------------------------------------|--|-------------------------------------|--|
| 1. Name of Deceased | | 2. Sex | | 3. Age | |
| 4. Date of Death | | 5. Time of Death | | 6. Place of Death | |
| 7. Cause of Death | | 8. Manner of Death | | 9. Signature of Medical Examiner | |
| 10. Signature of Coroner | | 11. Signature of Registrar | | 12. Signature of Burial Officer | |
| 13. Signature of Undertaker | | 14. Signature of Funeral Home | | 15. Signature of Cemetery | |
| 16. Signature of Burial Society | | 17. Signature of Burial Association | | 18. Signature of Burial Society | |
| 19. Signature of Burial Association | | 20. Signature of Burial Society | | 21. Signature of Burial Association | |
| 22. Signature of Burial Society | | 23. Signature of Burial Association | | 24. Signature of Burial Society | |
| 25. Signature of Burial Association | | 26. Signature of Burial Society | | 27. Signature of Burial Association | |
| 28. Signature of Burial Society | | 29. Signature of Burial Association | | 30. Signature of Burial Society | |
| 31. Signature of Burial Association | | 32. Signature of Burial Society | | 33. Signature of Burial Association | |
| 34. Signature of Burial Society | | 35. Signature of Burial Association | | 36. Signature of Burial Society | |
| 37. Signature of Burial Association | | 38. Signature of Burial Society | | 39. Signature of Burial Association | |
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| 70. Signature of Burial Society | | 71. Signature of Burial Association | | 72. Signature of Burial Society | |
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| 91. Signature of Burial Association | | 92. Signature of Burial Society | | 93. Signature of Burial Association | |
| 94. Signature of Burial Society | | 95. Signature of Burial Association | | 96. Signature of Burial Society | |
| 97. Signature of Burial Association | | 98. Signature of Burial Society | | 99. Signature of Burial Association | |
| 100. Signature of Burial Society | | 101. Signature of Burial Association | | 102. Signature of Burial Society | |

Arthur S. Kraus

100-111111
M

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of Birth: [illegible]
5. Place of Birth: [illegible]
6. Usual Residence: [illegible]
7. Date of Death: [illegible]
8. Time of Death: [illegible]
9. Place of Death: [illegible]
10. Cause of Death: [illegible]
11. Manner of Death: [illegible]
12. Signature of Examiner: [illegible]
13. Signature of Physician: [illegible]
14. Signature of Coroner: [illegible]
15. Signature of Medical Examiner: [illegible]

1435-111111
11-11-11

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 08741

8747

| | | | | | | | |
|--|----------------------------------|---|--|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Severna Park | | | c. LENGTH OF STAY IN 1b
75 years | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural-Severna Park | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS
Rt. 2 Box 319 | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) John First Henry Middle Johnson Last | | | | 4. DATE OF DEATH
Month 8 Day 11 Year 1961 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7-6-91 | | 9. AGE (In years last birthday) yrs.
70 | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Minister | | | 10b. KIND OF BUSINESS OR INDUSTRY
***** | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. |
| 13. FATHER'S NAME
John Henry Johnson, Sr. | | | | 14. MOTHER'S MAIDEN NAME
Laura Brown* Murdock | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
216-07-4775A | | 17. INFORMANT
son-Phillip Johnson Address 1 Gilmer St. Annapolis, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
331X DUE TO Gen arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
(c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from 1958 , 19____, to 1961 , 19____, that I last saw the deceased alive on 8-5-61 , 19____, and that death occurred at 2 A M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE [Signature] M.D. | | | | ADDRESS (Street, city or town, state) Severna Park | | DATE SIGNED [Signature] | |
| PHYSICIAN'S NAME (Type) Robert J. Halpin | | | | Severna Park Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Aug. 15-61 | | 22c. NAME OF CEMETERY OR CREMATORY
Town Neck | | 22d. LOCATION (City, town, or county) (State)
A.A.Co. Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
C.E. Hicks III | | | | ADDRESS
Annapolis, Maryland | | 24a. REC'D BY REGISTRAR
AUG 18 61 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Harris | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers and pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cause papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8748
CERTIFICATE OF DEATH

08742

| | | | |
|---|-------------------------------|--|----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <i>Anne Arundel Co.</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE <i>MARYLAND</i> b. COUNTY <i>WASHINGTON</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CROWNSVILLE</i> | | c. LENGTH OF STAY IN 1b <i>33 DAYS</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>CROWNSVILLE STATE HOSPITAL</i> | | d. STREET ADDRESS <i>336 N. JONATHAN ST.</i> | |
| 3. NAME OF DECEASED
(Type or print) <i>LEILA</i> First <i>JOHNSON</i> Middle <i>-</i> Last | | 4. DATE OF DEATH
Month <i>8</i> Day <i>19</i> Year <i>1961</i> | |
| 5. SEX <i>FEMALE</i> | 6. COLOR OR RACE <i>NEGRO</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>5/1/1888</i> |
| 9. AGE (In years last birthday) <i>73</i> yrs. | | IF UNDER 1 YEAR: Months <i>0</i> Days <i>0</i> IF UNDER 24 HRS.: Hours <i>0</i> Min. <i>0</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>UNEMPLOYED</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>-</i> | |
| 11. BIRTHPLACE (County & State, or foreign country) <i>?</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i> | |
| 13. FATHER'S NAME <i>JIMMY JOHNSON</i> | | 14. MOTHER'S MAIDEN NAME <i>PHILLIS STEVENS</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> | | 16. SOCIAL SECURITY NO. <i>-</i> | |
| 17. INFORMANT <i>Dr. I. Turek</i> | | Address <i>Crownsville State Hospital</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<i>260X</i> IMMEDIATE CAUSE (a) <i>Diabetes Mellitus</i>
DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(e), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour <i>a.m.</i> <i>19</i> Month, Day, Year | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>7/17</i> , 19 <i>61</i> , to <i>8/19</i> , 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>8/19</i> , 19 <i>61</i> , and that death occurred at <i>6:30 P.</i> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>L. Benedict</i> | | 22b. DATE SIGNED <i>8/21/61</i> | |
| 22c. PHYSICIAN'S NAME (Type) <i>L. Benedict, M. D.</i> | | 22d. ADDRESS <i>Crownsville State Hospital, Maryland</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE THEREOF <i>Aug 24 1961</i> | |
| 23c. NAME OF CEMETERY OR CREMATORY <i>Rose Hill Cemetery</i> | | 23d. LOCATION (City, town or county) (State) <i>Hagerstown Md</i> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>John R Watson Jr</i> | | 25a. REC'D BY REGISTRAR <i>AUG 28 '61</i> | |
| ADDRESS <i>Hagerstown Md</i> | | 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | |

M

Wm. H. H. Co.

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HAGERSTOWN

20 DAY

CROWN

336 N. JONATHAN ST.

CROWN

10

JOHNSON

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1882

FRANK

U.S.A.

UNEMPLOYED

PHILIP STEVENS

JIMMY JOHNSON

to I. L. (Crown)

Diocese of

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Crown

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **118743**

| | | | |
|---|---------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY W. A. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Annapolis | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Annapolis | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
A. A. General Hosp. | | d. STREET ADDRESS
17 College Ave | |
| 3. NAME OF DECEASED
(Type or print) Ronald Joseph Johnson | | 4. DATE OF DEATH
Month 8 Day 9 Year 1961 | |
| 5. SEX
Male | 6. COLOR OR RACE
Col. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1-16-1941 |
| 9. AGE (In years last birthday)
20 yrs. | | IF UNDER 1 YEAR
Months 8 Days 9 Hours 19 Min. 61 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Chaffin Helper | | 10b. KIND OF BUSINESS OR INDUSTRY
N. A. Van Lines | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Clarence Johnson Jr. | | 14. MOTHER'S MAIDEN NAME
Margaret Bond | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
17 College Ave. | |
| 17. INFORMANT
Mary Shymon | | Address
17 College Ave. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Myeloma
DUE TO
Conditions, if any, which gave rise to immediate cause (b) Sudden
DUE TO
(a), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>
Auto | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
Auto Struck Park Drive | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour 5-5 P. M. 1961 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>
Driving | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | | 20f. (City or town) (County) (State)
Annapolis | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE
E. L. Linkardt | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
E. L. Linkardt | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
8-12-61 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Brewer Hill | | 22d. LOCATION (City, town, or county) (State)
Annapolis, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
William Reese, Jr. | | 24a. REC'D BY REGISTRAR
DATE AUG 14 '61 | |
| | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kinn | |

MEDICAL CERTIFICATION

THE DEPARTMENT OF HEALTH - BOSTON OFFICE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NO. 1013

DECEASED
NAME

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH OF SPOUSE

PLACE OF DEATH OF SPOUSE

DATE OF DEATH OF FATHER

NAME OF FATHER

DATE OF DEATH OF MOTHER

NAME OF MOTHER

DATE OF DEATH OF BROTHER

NAME OF BROTHER

DATE OF DEATH OF SISTER

NAME OF SISTER

DATE OF DEATH OF UNCLE

NAME OF UNCLE

DATE OF DEATH OF AUNT

NAME OF AUNT

DATE OF DEATH OF GRANDFATHER

NAME OF GRANDFATHER

DATE OF DEATH OF GRANDMOTHER

NAME OF GRANDMOTHER

DATE OF DEATH OF NEPHEW

NAME OF NEPHEW

DATE OF DEATH OF NIECE

NAME OF NIECE

DATE OF DEATH OF COUSIN

NAME OF COUSIN

DATE OF DEATH OF OTHER

NAME OF OTHER

DATE OF DEATH OF OTHER

NAME OF OTHER

DATE OF DEATH OF OTHER

NAME OF OTHER

DATE OF DEATH OF OTHER

NAME OF OTHER

DATE OF DEATH OF OTHER

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NAME OF OTHER

DATE OF DEATH OF OTHER

NAME OF OTHER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completed in the presence of the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08744

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>A.A. Co.</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Leithicum Hgts</u>
c. LENGTH OF STAY IN lb <u>MARYLAND</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>509 La Claire Ave</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Md</u>
b. COUNTY <u>3 VOI-4</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>
d. STREET ADDRESS <u>3136 Leeds St.</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>Helen M. Jones</u> | | 4. DATE OF DEATH
Month Day Year
<u>Aug. 17. 1961</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Dec. 9, 1890</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>H. W.</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Balto. Md</u> | |
| 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | |
| 13. FATHER'S NAME
<u>Louis Raap</u> | | 14. MOTHER'S MAIDEN NAME
<u>Helen Marie Gerlach</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give year or dates of service)</u> | | 16. SOCIAL SECURITY NO. <u>Mr. Bernard Hease Lin. Hgts.</u> | |
| 17. INFORMANT
<u>Mr. Bernard Hease Lin. Hgts.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of Colon & Metastasis</u>
153.8 DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>ASCRD</u>
causing the underlying cause listed. (c) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
<u>months</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
<u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>Jan 7, 1961</u> to <u>8/17</u> , 19 <u>61</u> , that (I) (<u>no</u>) last saw the deceased alive on <u>8/15</u> , 19 <u>61</u> , and that death occurred at <u>7:30</u> A.M., from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>James Nolan</u> | | 22b. DATE SIGNED
<u>8/18/61</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>J. J. NOLAN</u> | | 22d. ADDRESS
<u>Baltimore 29, Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>8/21/61</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Landon Dk</u> | 23d. LOCATION (City, town or county) (State)
<u>Balto. Md</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>W. H. 4101 Edmondson Ave</u> | | 25a. REC'D BY REGISTRAR
DATE <u>AUG 21 '61</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Thomas</u> | | | |

VR A15 (4)
15M 9/60

65

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8751

CERTIFICATE OF DEATH

Reg. Dist. No.

18745

| | | | |
|---|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY ANNE ARUNDEL MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY ANNE ARUNDEL | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSVILLE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSVILLE | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SEVERN SIDE FARM | | d. STREET ADDRESS SEVERN SIDE FARM | |
| 3. NAME OF DECEASED (Type or print) First Middle Last FRANK DELBERT KYLE | | 4. DATE OF DEATH Month Day Year AUGUST 28 1961 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 14, 1872 |
| 9. AGE (In years last birthday) 88 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Truck farm | |
| 11. BIRTHPLACE (State or foreign country) Ohio | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Wesley Lanfrere Kyle | | 14. MOTHER'S MAIDEN NAME Ann Packard | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Mr Frank D. Kyle Jr- Son- same as # 2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis
DUE TO
(c) 10 Years | | INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Oct 1946 to Aug 28 1961 , that I last saw the deceased alive on Aug 26 1961 , and that death occurred at 8:50 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Edward G. Skerrett M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED | |
| PHYSICIAN'S NAME (Type) Edward G. Skerrett MD | | Gambrills, Maryland Aug. 28, 1961 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF SEPT. 1, 61 | |
| 22c. NAME OF CEMETERY OR CREMATORY Baldwin Memorial Cem. | | 22d. LOCATION (City, town, or county) (State) Millersville, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Md. | | 24a. REC'D BY REGISTRAR DATE SEP 1 '61 | |
| 24b. REGISTRAR'S SIGNATURE Arthur L. Hanes | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1921

88

Oct. 11, 1921

U.S.

Ann Jackson

Residence

to

X

Nov. 2, 1921

Year

+

1921

+

1921

1921

8752

8752

118746

CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

| | | | |
|--|---------------------------|--|----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY ANNE ARUNDEL MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
a. STATE MD. b. COUNTY ANNE ARUNDEL | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 ANNAPOLIS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 53 Colhage Ave | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Lottie E. LEE | | 4. DATE OF DEATH 8 30 1961 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-4-1884 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY HOME | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME ALFRED OWEN BAKER | | 14. MOTHER'S MAIDEN NAME CHARLOTTE BRUEN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. EDWARD LEE #2 | |

| | | | |
|---|---|--|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
420.5 DUE TO Pulmonary Edema, acute
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO arteriosclerotic Heart Disease | | INTERVAL BETWEEN ONSET AND DEATH
1 day 1
2 hrs 1 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 8/29 1961 to 8/30 1961 , that (I) (we) last saw the deceased alive on 8/29 1961 , and that death occurred at 6 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Richard I. Hochman | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D. | | 22d. ADDRESS 100 Cathedral St., Annapolis, Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 9-1-61 | 23c. NAME OF CEMETERY OR CREMATORY ST. ANNES | 23d. LOCATION (City, town, or county) (State) ANNAPOLIS MD. |
| 24. FUNERAL DIRECTOR'S SIGNATURE John M. To Love Sons Annapolis, Md. | | 25a. REC'D BY REGISTRAR DATE SEP 5 '61 | |
| | | 25b. REGISTRAR'S SIGNATURE M. L. S. Kraus | |

CERTIFICATE OF DEATH

1955

1955

State of New York

County of Hamilton

No.

Decedent

A. J. Baker

Age

65

Sex

Male

Marital Status

Widowed

Occupation

Farmer

Place of Birth

Hamilton, New York

Date of Death

October 1, 1955

Time of Death

10:30 AM

Place of Death

Home

Signature of Physician

[Signature]

Signature of Coroner

[Signature]

Signature of Registrar

[Signature]

Signature of Burial Officer

[Signature]

Signature of Undertaker

[Signature]

Signature of Witness

[Signature]

Signature of Minister

[Signature]

Signature of Priest

[Signature]

Signature of Rabbi

[Signature]

Signature of Imam

[Signature]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8753 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08747

1
FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|----------------------------------|--|-------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Annapolis | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Annapolis | | d. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Chase Home | | | | e. STREET ADDRESS
22 Maryland Ave. | | | |
| 3. NAME OF DECEASED
(Type or print) MARGARITA^{1st} BLIGHT Middle LE SUEUR
Marguerite Le-Sueur | | | | 4. DATE OF DEATH
Month 8 Day 18 Year 1961 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3-4-1875 | | 9. AGE (In years last birthday)
86 yrs. | IF UNDER 1 YEAR
Months 8 Days 18 Hours 1961 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Nurse | | 10b. KIND OF BUSINESS OR INDUSTRY
R.N. Ret. | | 11. BIRTHPLACE (State or foreign country)
Chile, S.A. | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
Samuel Blight Samuel Blight | | | | 14. MOTHER'S MAIDEN NAME
Cynthia Hines | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Benjamin W Le Sueur | | Address (2) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxiation - Due to strangulation | | | | | | | |
| 983X DUE TO | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. | | | | | | (b) DUE TO | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Unknown 8-18 19 61 | | 20d. INJURY OCCURRED
While <input checked="" type="checkbox"/> Not While <input type="checkbox"/>
at work <input checked="" type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Chase Home | | 20f. (City or town) (County) (State)
Annapolis A. Arundel Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
William V. Lovitt, Jr., M.D. | | | | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | | | DATE SIGNED
8-19-61 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
8-22-61 | | 22c. NAME OF CEMETERY OR CREMATORY
Woodlawn | | 22d. LOCATION (City, town, or country) (State)
Baltimore Md. | |
| 23. FUNERAL DIRECTOR
John M. Taylor and Sons Annapolis, Md. | | | | 24a. REC'D BY REGISTRAR
AUG 22 '61 | | 24b. REGISTRAR'S SIGNATURE
Arthur J. Hines | |

100-100000

John N. Taylor and Sons, Annapolis, Md.

Annapolis

John N. Taylor and Sons

MANHATTAN LIGHT

22 Maryland Ave.

1875-1876

2

Female

U.S. Rep.

Chas. E. ...

Male

Cynthia ...

John N. Taylor and Sons

John N. Taylor and Sons - Annapolis, Md.

Annapolis

Annapolis

John N. Taylor and Sons, Annapolis, Md.

Woodbury

1875-1876

Female

John N. Taylor and Sons, Annapolis, Md.

2

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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8754

118748

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Annapolis</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>10 Annapolis</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION)
<u>105 Market St.</u> | | | | d. STREET ADDRESS
<u>1 105 Market St.</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>John</u> Middle <u>G.</u> Last <u>Lewnes</u> | | | | 4. DATE OF DEATH
Month <u>August</u> Day <u>1</u> Year <u>1961</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>9-24-1895</u> | |
| 9. AGE (In years lost birthday)
<u>63</u> yrs. | | IF UNDER 1 YEAR
Months <u>63</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | | IF UNDER 24 HRS.
Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>RESTAURANT</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>CO-OWNER RET.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Greece</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | | | | | |
| 13. FATHER'S NAME
<u>George Lewnes</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>"UNK"</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year of entry into service)
<u>Yes</u> <u>WWI</u> | | | | 16. SOCIAL SECURITY NO.
<u>Eleftheria Lewnes #2</u> | | | |
| 17. INFORMANT
<u>Eleftheria Lewnes</u> | | | | Address <u>#2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>
DUE TO <u>527-1</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis Heart Disease</u>
DUE TO <u>Pulmonary emphysema & fibrosis</u>
(c) <u></u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 days</u>
<u>3 wks.</u>
<u>4 yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 <u>527-1</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 10, 1959</u> to <u>8-1-1961</u> , that (I) (we) last saw the deceased alive on <u>8-1-1961</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>James R. Martin</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>8-3-61</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>JAMES R. MARTIN</u> | | | | 22d. ADDRESS
<u></u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>8-4-1961</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>St. James Creek</u> | | 23d. LOCATION (City, town, or county) (State)
<u>Annapolis Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>John M. Taylor & Sons</u> | | | | ADDRESS
<u>Annapolis, Md.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>AUG 7 '61</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hume</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician at the hospital or at the residence of the deceased. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8755

08749

M

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| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
<i>Anne Arundel</i>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<i>Glen Burnie</i>
c. LENGTH OF STAY IN 1b
<i>10 yrs.</i>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<i>118 Wilson Blvd. S.W.</i> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
<i>Maryland</i>
b. COUNTY
<i>Anne Arundel</i>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<i>Glen Burnie</i>
d. STREET ADDRESS
<i>118 Wilson Blvd. S.W.</i>
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
<i>Elizabeth D. Litz</i> | 4. DATE OF DEATH
Month
<i>Aug.</i>
Day
<i>5</i>
Year
<i>1961</i> | | |
| 5. SEX
<i>Female</i> | 6. COLOR OR RACE
<i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>Nov. 19-1883</i> |
| 9. AGE (In years last birthday)
<i>77</i> yrs. | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | 11. BIRTHPLACE (County & State, or foreign country)
<i>Germany</i> | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> |
| 13. FATHER'S NAME
<i>Joseph HIAKA</i> | 14. MOTHER'S MAIDEN NAME
<i>Marie (unknwn)</i> | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
<i>NO</i> | |
| 16. SOCIAL SECURITY NO.
<i>NONE</i> | | 17. INFORMANT
<i>Dr. O'Herlihy 5 Central Ave.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i>
DUE TO (b) <i>Chronic Coronary Heart Failure</i>
DUE TO (c) <i>Glomerulonephritis</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I
<i>331X</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>minutes</i>
<i>months</i>
<i>years</i> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
<i>19</i> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <i>July 1, 1961</i> to <i>Aug 5, 1961</i> , that (I) (we) last saw the deceased alive on <i>Aug 1, 1961</i> , and that death occurred at <i>7:15</i> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Hilary T O'Herlihy</i>
22c. PHYSICIAN'S NAME (Type)
<i>HILARY T O'HERLIHY MD</i> | | 22b. DATE SIGNED
<i>8/5/61</i> | 22d. ADDRESS
<i>5 CENTRAL AVE, Glen Burnie.</i> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | 23b. DATE THEREOF
<i>8-9-61</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Glen Haven Cemetery</i> | 23d. LOCATION (City, town or county) (State)
<i>Glen Burnie md.</i> |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>Robert P. Wan</i> | | 25a. REC'D BY REGISTRAR
<i>AUG 9 '61</i> | 25b. REGISTRAR'S SIGNATURE
<i>Arthur S. Hanna</i> |



3528

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be completed by the attending physician and signed by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
8755

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08750

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY
Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Crownsville
c. LENGTH OF STAY in 1b
25 years 6mos. 28 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Crownsville State Hospital | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore
d. STREET ADDRESS
304 Dallas Street
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Gideon | | 4. DATE OF DEATH
Month
8
Day
29
Year
19 61 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
UNKNOWN | 8. DATE OF BIRTH
1880 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Unknown | | 11. BIRTHPLACE (County & State, or foreign country)
North Carolina | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
No | | 16. SOCIAL SECURITY NO.
Unknown | |
| 17. INFORMANT
Hospital Records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Cardiovascular Disease
(c) with Hypertension
DUE TO
cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH
10 minutes
Years |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
----- | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. -----
p.m. ----- | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
----- |
| 20f. (City or town)
----- | | 20g. (County)
----- | |
| 20h. (State)
----- | | 20i. (State)
----- | |
| 21. I certify that (I) (this hospital) attended the deceased from 2/1 1961 to 8/29 1961 , that (I) (we) last saw the deceased alive on 8/29 1961 , and that death occurred at 4:35 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
L. Benedict | | 22b. DATE SIGNED
8/30/61 | |
| 22c. PHYSICIAN'S NAME (Type)
L. Benedict, M. D. | | 22d. ADDRESS
Crownsville State Hospital, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal 8-31-61 | | 23b. DATE THEREOF
21.09.61 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Med. Schol Balto. Md. | | 23d. LOCATION (City, town or county)
Balto. Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
William Reese, Jr. - Balto. Md. | | 25a. REC'D BY REGISTRAR
SEP 6 '61 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Thomas | | 25c. REGISTRAR'S SIGNATURE
Arthur S. Thomas | |

M

8757

CERTIFICATE OF DEATH

Reg. Dist. No.

08751

| | | | | | | | |
|---|--|---|---|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Maryland</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u>
b. COUNTY <u>Anne Arundel</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Laurel (Rural)</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Laurel (Rural)</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Laurel Race Track, Laurel, Maryland</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Frances</u> Middle <u>Requa</u> Last <u>Martin</u> | | | | 4. DATE OF DEATH
Month <u>August</u> Day <u>8</u> Year <u>1961</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>January 15, 1899</u> | | 9. AGE (In years last birthday)
<u>62</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HRS.
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Tarrytown, N.Y.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>James Milton Requa</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Myra Ruth Lee</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u> </u> | | 17. INFORMANT
<u>George Harris Martin, Jr.</u> Address <u>Laurel, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Colon</u>
<u>153.9</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u> </u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u> </u> | | | | | |
| 20c. TIME OF INJURY
Hour <u> </u> o. m. <u> </u> p. m. <u> </u> | Month <u> </u> Day <u> </u> Year <u>1961</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | 20f. (City or town)
<u> </u> | (County)
<u> </u> | (State)
<u> </u> | |
| 21. I certify that I attended the deceased from <u>October 22</u> , 19 <u>60</u> , to <u>August 8</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>August 8</u> , 19 <u>61</u> , and that death occurred at <u>10 P</u> M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>612 Main Street, Laurel, Maryland</u> DATE SIGNED <u> </u> | | | | | | | |
| ACTUAL SIGNATURE <u>J. Richard Compton, M.D.</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>J. Richard Compton, M.D.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>Aug. 11, 1961</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Fort Lincoln Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Colmar Manor, Maryland</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>De Witt Donaldson, Laurel, Md.</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>AUG 14 '61</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. Kline</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1927

| | | | | | | | | | | | |
|------------------------|--|-------------|--|----------------|--|-------------------|--|---------------|--|----------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES H. HARRIS | | 45 | | M | | W | | JAN 15 1882 | | BALTIMORE, MD. | |
| MARRIAGE | | DATE | | PLACE | | NAME OF SPOUSE | | DATE OF DEATH | | PLACE OF DEATH | |
| MARRIED | | JAN 15 1905 | | BALTIMORE, MD. | | JAMES H. HARRIS | | JAN 15 1927 | | BALTIMORE, MD. | |
| OCCUPATION | | DATE | | PLACE | | NAME OF EMPLOYER | | DATE OF DEATH | | PLACE OF DEATH | |
| LABORER | | JAN 15 1927 | | BALTIMORE, MD. | | JAMES H. HARRIS | | JAN 15 1927 | | BALTIMORE, MD. | |
| CAUSE OF DEATH | | DATE | | PLACE | | NAME OF PHYSICIAN | | DATE OF DEATH | | PLACE OF DEATH | |
| HEART DISEASE | | JAN 15 1927 | | BALTIMORE, MD. | | JAMES H. HARRIS | | JAN 15 1927 | | BALTIMORE, MD. | |
| MANNER OF DEATH | | DATE | | PLACE | | NAME OF PHYSICIAN | | DATE OF DEATH | | PLACE OF DEATH | |
| NATURAL | | JAN 15 1927 | | BALTIMORE, MD. | | JAMES H. HARRIS | | JAN 15 1927 | | BALTIMORE, MD. | |
| SIGNATURE OF PHYSICIAN | | DATE | | PLACE | | NAME OF PHYSICIAN | | DATE OF DEATH | | PLACE OF DEATH | |
| JAMES H. HARRIS | | JAN 15 1927 | | BALTIMORE, MD. | | JAMES H. HARRIS | | JAN 15 1927 | | BALTIMORE, MD. | |
| SIGNATURE OF DECEASED | | DATE | | PLACE | | NAME OF DECEASED | | DATE OF DEATH | | PLACE OF DEATH | |
| JAMES H. HARRIS | | JAN 15 1927 | | BALTIMORE, MD. | | JAMES H. HARRIS | | JAN 15 1927 | | BALTIMORE, MD. | |
| SIGNATURE OF WITNESSES | | DATE | | PLACE | | NAME OF WITNESSES | | DATE OF DEATH | | PLACE OF DEATH | |
| JAMES H. HARRIS | | JAN 15 1927 | | BALTIMORE, MD. | | JAMES H. HARRIS | | JAN 15 1927 | | BALTIMORE, MD. | |
| SIGNATURE OF REGISTRAR | | DATE | | PLACE | | NAME OF REGISTRAR | | DATE OF DEATH | | PLACE OF DEATH | |
| JAMES H. HARRIS | | JAN 15 1927 | | BALTIMORE, MD. | | JAMES H. HARRIS | | JAN 15 1927 | | BALTIMORE, MD. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards, papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|--|--|---|--|---|---|--|--|---|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | |
| 8758 | | | | | CERTIFICATE OF DEATH | | | | | | | | | |
| 08752 | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Pasadena (Rural)
c. LENGTH OF STAY IN 1b
Pasadena (Rural)
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Rte 11, Box 120 | | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
a. STATE Md. b. COUNTY AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Pasadena (Rural)
d. STREET ADDRESS
Rte 11, Box 120
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
William Wesley Matthews | | | | | 4. DATE OF DEATH
August 30 19 61 | | | | | | | | | |
| 5. SEX
M | | 6. COLOR OR RACE
MW | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Oct. 3, 1877 | | 9. AGE (In years last birthday)
83 yrs. | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Minister | | 10b. KIND OF BUSINESS OR INDUSTRY
American Rescue | | 11. BIRTHPLACE (County & State, or foreign country)
Taylor's Island, Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | | |
| 13. FATHER'S NAME
Samuel Henry Matthews | | | | | 14. MOTHER'S MAIDEN NAME
Sally Ann Ruarke | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) no | | | | | 16. SOCIAL SECURITY NO.
220-36-5004 | | | | | 17. INFORMANT
Mr. Charles Matthews, same as 2 | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary thrombosis
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic heart disease
(c) Cardiac decompensation
causa last. }
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 hours
1 year
2 months | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
6/15 | | 20g. (County)
1961 | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 6/15 to 8/30 , 19 61 , that (I) (we) last saw the deceased alive on 8/30 , 19 61 , and that death occurred at 1:20 P.M. from the causes and on the date stated above. | | | | | | | | | | | | | | |
| 22a. SIGNATURE
R.M. McLaughlin | | | | | 22b. DATE SIGNED
8/30/61 | | 22c. PHYSICIAN'S NAME (Type)
R.M. McLaughlin | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | 23b. DATE THEREOF
9/2/61 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Memorial | | 23d. LOCATION (City, town or county)
Glen Burnie, Md | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Hopping and Kirkley | | | | | 25a. REC'D BY REGISTRAR
SEP 5 '61 | | 25b. REGISTRAR'S SIGNATURE
Charles S. Harris | | | | | | | |

1075

2278

M

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1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 must be retained for 10 years.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|------------------------------|---|---|--|---|--|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 8759 108753 | | | | | | | | | | | |
| 1. PLACE OF DEATH
e. COUNTY <i>P.A. Co.</i> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
e. STATE <i>MD</i> b. COUNTY <i>AA</i> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Amosopolis</i> | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>X Jessops</i> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<i>D.O.A. - Anne Arundel gen.</i> | | | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <i>John</i> Middle <i>W.</i> Last <i>McCullough</i> | | | | | | DATE OF DEATH
Month <i>8</i> Day <i>31</i> Year <i>1961</i> | | | | | |
| 5. SEX
<i>M</i> | | 6. COLOR OR RACE
<i>W</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>6-11-16</i> | | 9. AGE (In years last birthday)
<i>45</i> yrs. | | IF UNDER 1 YEAR
Months <i>4</i> Days <i>5</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Salesman</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>CAR</i> | | | | 11. BIRTHPLACE (State or foreign country)
<i>WVa.</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>US</i> | |
| 13. FATHER'S NAME
<i>Harold W. McCullough</i> | | | | | | 14. MOTHER'S MAIDEN NAME
<i>Umble</i> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<i>?</i> | | | | | | 16. SOCIAL SECURITY NO.
<i>210-01-0447</i> | | 17. INFORMANT
<i>Mrs. Ester McCullough Jessops, Md.</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Carbide</i>
434.4 DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b)
(c)
INTERVAL BETWEEN ONSET AND DEATH
<i>Instant</i> | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m. <i>19</i> | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <i>Cholera</i> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county)
ACTUAL SIGNATURE <i>E. L. Richardt</i> M.D.
EXAMINER'S NAME (Type) <i>E. L. Richardt</i> DATE SIGNED <i>8/31/61</i> | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | 22b. DATE THEREOF
<i>9-3-61</i> | | | 22c. NAME OF CEMETERY OR CREMATORY
<i>Steel Cemetery</i> | | | 22d. LOCATION (City, town, or county) (State)
<i>Friendsville Md.</i> | | |
| 23. FUNERAL DIRECTOR
ADDRESS
<i>Robert Kyle Smith, Jr. Kensington, Md.</i> | | | | | | 24a. REC'D BY REGISTRAR
DATE <i>SEP 7 '61</i> | | 24b. REGISTRAR'S SIGNATURE
<i>Arthur S. Hines</i> | | | |

100-100000

(M)

(1)

Completed

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

VR A15 (4)
ISM 9/59

may be filled in by the funeral director, or by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE NATIONAL CEMETERY

5401 FREDERICK AVENUE
BALTIMORE 28, MARYLAND

AUG 28 1961

A. P. BERNHARDT
Superintendent

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--------------------------------|--|--------------------------------------|---|--|---|--------------------------|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Ft Geo G. Meade | | c. LENGTH OF STAY IN 1b
24 hrs | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hyattsville | | 1839-2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
KIMBROUGH ARMY HOSPITAL | | | | d. STREET ADDRESS
5302 Hamilton St | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First - Middle - Last MCGANN | | 4. DATE OF DEATH
Month AUGUST Day 24 Year 19 61 | | | | | |
| 5. SEX
Male | 6. COLOR OR RACE
Cau | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
23 Aug 61 | | 9. AGE (In years last birthday)
yrs. 1 | IF UNDER 1 YEAR
Months 1 Days 1 Hours 1 Min. | IF UNDER 24 HRS.
Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
- | | 10b. KIND OF BUSINESS OR INDUSTRY
- | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Joseph McGann | | | | 14. MOTHER'S MAIDEN NAME
Nancy Raines | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
- | | 16. SOCIAL SECURITY NO.
- | | 17. INFORMANT
Mother, 5302 Hamilton St Hyattsville, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity
7615 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Abruptio placenta
DUE TO (c) 24 hours | | | | | | INTERVAL BETWEEN ONSET AND DEATH
24 hours | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) attended attended the deceased from 23 Aug 19 61 to 24 Aug 19 61 that (I) the last saw the deceased alive on 24 Aug 19 61 and that death occurred 10:40 P from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Stuart Bernstein Capt MC | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
24 Aug 61 | |
| 22c. PHYSICIAN'S NAME (Type)
STUART M. BERNSTEIN, Capt., M.C. | | | | 22d. ADDRESS
Kimbrough AH Ft Geo G. Meade, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF
8/20/61 | | 23c. NAME OF CEMETERY OR CREMATORY
Balt National | | 23d. LOCATION (City, town, or county) (State)
Balt. Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Carl B. Wolventon | | | | ADDRESS
6306 Belair Rd | | 25a. REC'D BY REGISTRAR
DATE 8/28/61 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Hanna | | | |

-2050231XV2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased is not taken to a hospital, the certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completed in accordance with the law. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. If the deceased is not taken to a hospital, the certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completed in accordance with the law. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

(I)

MEDICAL CERTIFICATION

| | | | | | | | |
|---|----------------------------------|---|---|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Maryland</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Elkton</u> | | c. LENGTH OF STAY IN 1b
<u>30 yrs.</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Elkton - Millersville</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>Jumper Hole Rd - Box 311, Millersville</u> | | | | d. STREET ADDRESS
<u>Jumper Hole Rd. Box 311, Millersville</u> | | | |
| 3. NAME OF DECEASED (Type or print)
<u>Amelia</u> | | 4. DATE OF DEATH
<u>Aug 6 1961</u> | | a. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Oct. 30 - 1886</u> | 9. AGE (In years last birthday)
<u>74 yrs.</u> | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>OWN Home</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Germany</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Karl Gellin</u> | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>NONE</u> | | 17. INFORMANT
<u>E. H. Meyer - Balto. 26 - Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>acute pulmonary edema.</u>
420.1 DUE TO (b) <u>Coronary arteriosclerotic Heart Disease 3 years.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u> </u> | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>12 hours.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov 3</u> , 19 <u>49</u> , to <u>Aug 6</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Aug 5</u> , 19 <u>61</u> , and that death occurred at <u>3 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>R. M. McLaughlin, M.D.</u> | | 22b. PHYSICIAN'S NAME (Type)
<u>R. M. McLaughlin</u> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS
<u>3708 Mountain Rd. Pasadena, Md.</u> | | 22c. DATE SIGNED
<u>8/7/61</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>8-9-1961</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>Brooklyn R.F.D. Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Robert A. Ware</u> | | | | ADDRESS
<u>Alton Byrnie, Md.</u> | | 25a. REC'D BY REGISTRAR
<u>AUG 9 '61</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kenna</u> | | | |

1930

1930

(M)

For your reference, the following is a list of the
persons who have been admitted to the
club since the last meeting. The names are
listed in alphabetical order. The names of the
persons who have been admitted to the club
since the last meeting are listed in the
list below. The names of the persons who
have been admitted to the club since the
last meeting are listed in the list below.

(J)

The following is a list of the persons who
have been admitted to the club since the
last meeting. The names are listed in
alphabetical order. The names of the
persons who have been admitted to the club
since the last meeting are listed in the
list below. The names of the persons who
have been admitted to the club since the
last meeting are listed in the list below.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completed in accordance with the law. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.
4 may be retained by the hospital or attending physician.
15M 9/60

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8762
CERTIFICATE OF DEATH
08756

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Annapolis | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
10 Annapolis | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Anne Arundel General Hospital | | | | d. STREET ADDRESS
43 Larkin St. | | | |
| 3. NAME OF DECEASED
(Type or print)
Margaret MERRITT | | | | 4. DATE OF DEATH
August 13 19 61 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
5-8-1903 | |
| 9. AGE (In years last birthday)
58 yrs. | | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (County & State, or foreign country)
South Carolina | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | | | |
| 13. FATHER'S NAME
Unknown | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT
Mary Coates 43 Larkin St. | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b)
DUE TO (c)
Coronary Occlusion | | | | INTERVAL BETWEEN ONSET AND DEATH
about 3 hrs | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (husband) attended the deceased from 7-27-61 , 19 8-13-61 , that (I) (me) last saw the deceased alive on Aug. 13, 19 61 , and that death occurred at 9:40 P.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
A. T. Allen | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
8/14/61 | |
| 22c. PHYSICIAN'S NAME (Type)
A. T. Allen | | | | 22d. ADDRESS
62 Cathedral St., Annapolis, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
8-17-1961 | | 23c. NAME OF CEMETERY OR CREMATORY
Brewer Hall | | 23d. LOCATION (City, town or county) (State)
Annapolis Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
William Kiser | | | | ADDRESS
Annapolis Md. | | 25a. REC'D BY REGISTRAR
AUG 15 '61 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

1

1880-1881

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 4 may be retained by the hospital or attending physician, this certificate has been signed by the attending physician at the time of death. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician at the time of death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|---|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 8763 18757 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Annapolis | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
RURAL - Annapolis | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Anne Arundel General Hospital | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
(Type or print) Lee V. MOORE | | | | | | 4. DATE OF DEATH
Month August Day 15 Year 19 61 | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
July 8, 1878 | | 9. AGE (In years last birthday)
83 yrs. | | IF UNDER 1 YEAR
Months 8 Days 15 Hours 15 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Treasury Department | | | | 10b. KIND OF BUSINESS OR INDUSTRY
U. S. Government | | | | 11. BIRTHPLACE (County & State, or foreign country)
North Carolina | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
William Henry Moore | | | | | | 14. MOTHER'S MAIDEN NAME
Josephine Lawing | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | | | | 17. INFORMANT
Pattie T. Moore Address Wash. D.C. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Embolism
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b) Porter's Myocardial infarction
(c) 2 wks.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH 5 d. | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. 19
p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
Washington, D.C. | | 20g. (County)
D.C. | | 20h. (State)
D.C. | |
| 21. I certify that (I) observed attended the deceased from Aug. 10, 1961 to Aug. 14, 1961 , that (I) xx last saw the deceased alive on Aug. 14, 1961 , and that death occurred at 6:45 A.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Frank M. Shipley | | | | | | 22b. DATE
8/15/61 | | | 22c. PHYSICIAN'S NAME (Type)
Frank M. Shipley | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | | 23b. DATE THEREOF
August 18, 1961 | | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cemetery | | 23d. LOCATION (City, town or county) (State)
Washington, D. C. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Arthur Walters | | | | | | 25a. REC'D BY REGISTRAR
DATE AUG 21 '61 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Thomas | | | |

(M)

(1)

June 1901

July 1901

August 1901

June 1901

July 1901

July 1901

July 1901

August 1901

July 1901

August 1901

July 1901

August 1901

September 1901

October 1901

November 1901

December 1901

January 1902

February 1902

March 1902

April 1902

May 1902

June 1902

July 1902

August 1902

September 1902

October 1902

November 1902

December 1902

January 1903

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8764

08758

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY ANNE Arundel
MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Linthicum | | | | c. LENGTH OF STAY IN lb
3 yrs. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
525 Forest-View Road | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Thomas Middle Aloysius Last Moran | | | | 4. DATE OF DEATH
Month August Day 24th Year 61 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Sept. 19th 1878 | |
| 9. AGE (In years birthday) 82 | | IF UNDER 1 YEAR
Months 19 Days 61 | | IF UNDER 24 HRS.
Hours 19 Min. 61 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machinest(Ret.) | | | | 10b. KIND OF BUSINESS OR INDUSTRY
West Va. Paper Co. | | 11. BIRTHPLACE (County & State, or foreign country)
Piedmont W. Va. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
John Moran | | | | 14. MOTHER'S MAIDEN NAME
Mary Lennan | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 216-07-2295 | | 17. INFORMANT
Mr. Joseph T. Moran | | Address
Same as #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Heart Failure
443x DUE TO (b) Arteriosclerotic Hypertensive Corde
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Vascular Disease | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 weeks | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from June 1957 to August 1961 , that (I) (we) last saw the deceased alive on 8-22-1961 , and that death occurred at 1:30 P.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
C. R. MacDonald M.D. | | | | 22b. DATE SIGNED
8-24-61 | | 22c. PHYSICIAN'S NAME (Type)
C. R. MacDonald, M. D. | |
| 22d. ADDRESS
P. O. BOX 518, Glen Burnie, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Aug. 28, 1961 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Peter's Cemetery | | 23d. LOCATION (City, town or county) (State)
Westernport Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
for R.V. Singleton by E. B. King | | | | ADDRESS
Glen Burnie, Md. | | 25a. REC'D BY REGISTRAR
DATE AUG 28 '61 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Hanna | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)
15M 9/60

2000

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

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255-70-112

Mr. Joseph T. Quinn

Dr. J. H. B. Smith

8765

CERTIFICATE OF DEATH

08759

Reg. Dist. No.

| | | | |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2 Saitoun Ave. | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Halifax
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Littleton
d. STREET ADDRESS Rt 1
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First LAWRENCE Middle ERVIN Last MORRIS | | 4. DATE OF DEATH
Month August Day 24 Year 1961 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Nov 24, 1889 |
| 9. AGE (In years last birthday) 71 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Tabocca | |
| 11. BIRTHPLACE (State or foreign country) Littleton, N.C. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Marion Morris | | 14. MOTHER'S MAIDEN NAME Missouri Hammonds | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. unknown | |
| 17. INFORMANT Mrs. Ernest T. Godman, Daughter- Same as # 1 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY THROMBOSIS.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Hypertensive Cardiovascular Disease.
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. _____ p. m. _____ 19____ | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from _____, 19____ to _____, 19____ that I lost saw the deceased alive on _____, 19____ and that death occurred at 7:15 P.M. from the causes and on the date stated above.
DATE SIGNED _____
ADDRESS (Street, city or town, State)
609 Odenton Rd. | | | |
| ACTUAL SIGNATURE Febus F. Grunberg M.D. | | PHYSICIAN'S NAME (Type) Febus F. Grunberg MD Odenton, Maryland August 24, 1961 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| 22a. Removal-Burial Aug 24, 1961, Greenwood Cemetery | | 22d. Tarboro Edgecombe County, N.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley Funeral Home, Glen Burnie, | | 24a. REC'D BY REGISTRAR AUG 25 61 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Haines | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON

8765

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08760

| | | | |
|--|-------------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort George G. Meade | | c. LENGTH OF STAY IN 1b
18 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Kimbrough Army Hosp. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | d. STREET ADDRESS
1002 Rolling Road | |
| 3. NAME OF DECEASED (Type or print)
First RUTH Middle C. Last MORRISON | | 4. DATE OF DEATH
Month August Day 15 Year 19 61 | |
| 5. SEX
Female | 6. COLOR OR RACE
Cau | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
14 Oct 1897 |
| 9. AGE (In years last birthday)
63 yrs. | | 10. IF UNDER 1 YEAR
Months 63 Days 15 Hours 15 Min. | 11. IF UNDER 24 HRS.
Hours 15 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
- | |
| 11. BIRTHPLACE (State or foreign country)
Pa | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Andrew Schano | | 14. MOTHER'S MAIDEN NAME
Caroline Ertel | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
- | | 16. SOCIAL SECURITY NO.
219-100229 | |
| 17. INFORMANT
Son, Col John Morrison, Dept of Air Force | | Address
Washington D.C. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Jaundice and hepatomegaly
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) 78
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) examined the deceased from 15 Aug 19 61 3:26 PM and that the death occurred at 15 Aug 19 61 M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
J. I. Kaplan, Capt. M.C. | | 22b. DATE SIGNED
15 Aug 61 | |
| 22c. PHYSICIAN'S NAME (Type)
JULES I KAPLAN, Capt., M.C. | | 22d. ADDRESS
Kimbrough Army Hosp Ft Geo G. Meade, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
8-17-61 | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn | 23d. LOCATION (City, town, or county) (State)
Woodlawn Md. |
| 24. FUNERAL DIRECTOR'S SIGNATURE
H.W. Jenkins & Sons Co. | | 25a. REC'D BY REGISTRAR
DATE 17 '61 | |
| 4 905 York Rd.
Baltimore 12, Md; | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

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18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **08761**

2767

| | | | | | | | | |
|--|-------------------------------------|--|--|--|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY AA MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY AA | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Ft. Meade | | | c. LENGTH OF STAY IN 1b
1 1/2 hrs | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Jessups | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Ft. Meade Hospital | | | | d. STREET ADDRESS
House of Correction | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Garmon Middle James | | | | O'Quinn
O'Quinn | | 4. DATE OF DEATH
Month Aug. Day 30 Year 19 61 | | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Feb. 16, 1921 | | 9. AGE (In years last birthday)
40 yrs. | IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> | IF UNDER 24 HRS.
Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Guard Md. | | | 10b. KIND OF BUSINESS OR INDUSTRY
House of Corr. | | 11. BIRTHPLACE (State or foreign country)
Sandlick, Va. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
James Adlen O'Quinn | | | | 14. MOTHER'S MAIDEN NAME
Virginia C. Duty | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
233-24-9918 | | 17. INFORMANT Address
Ray Tingler, 8020 Midhaven, Balto. | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemorrhage due to Com. Comp. Fractures
825X DUE TO of the lt. Leg and Severance of rt. Foot
Conditions, if any, which gave rise to immediate cause (b) _____
(c), stating the underlying cause last. DUE TO _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 1/2 hrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Automobile Accident | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 3:05 a. m. 8/30 19 61 p. m. | | | 20d. INJURY OCCURRED
While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Rte 175 | | 20f. (City or town) Jessups AA Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>. | | | | | | | | |
| ACTUAL SIGNATURE
Gustave H. Faubert, Md. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Glen Burnie, Md. | | | | |
| EXAMINER'S NAME (Type)
Gustave H. Faubert, Md. | | | | DATE SIGNED
8/ 30/ 61 | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
9-2-1961 | | 22c. NAME OF CEMETERY OR CREMATORY
O'Quinn Family Plot | | 22d. LOCATION (City, town, or county) Dickenson County, Va. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
JOHN J. DUDA 7922 Wise Ave. 22, Maryland | | | | 24a. REC'D BY REGISTRAR
8/ 30/ 61 | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Harris | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your office. Register your signature on removal. TO FUNERAL DIRECTOR: Page 1 and 2 with Registrar permit. File pages 1 and 2 with Registrar permit. File pages 1 and 2 with Registrar permit.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be filled in by the attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with
page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

| Item 18 Film 299
11-6-61 ams | | | | | | | | | | |
|---|--|---|---|---|---|--|---|--|---|---|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND | | | | | | | | | | |
| 8768 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 08762 | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Ft Geo G. Meade | | | c. LENGTH OF STAY IN 1b
42 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X Glen Burnie | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Kimbrough Army Hospital | | | | | d. STREET ADDRESS
1006 Louise Ave | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Alpha Middle - Last Page | | | 4. DATE OF DEATH
Month August Day 1 Year 19 61 | | | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
Cau | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
12 May 1871 | | 9. AGE (In years lost birthday) 90 yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife (Retired) | | 10b. KIND OF BUSINESS OR INDUSTRY
- | | 11. BIRTHPLACE (State or foreign country)
Alabama | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 13. FATHER'S NAME
First name unknown Wigand | | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
- | | 16. SOCIAL SECURITY NO.
419 18 4411 | | 17. INFORMANT
Arnold Page (son) Montgomery, Ala | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
155.1 IMMEDIATE CAUSE (a) Cardiac and respiratory arrest
DUE TO Wide spread metastasis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adenocarcinoma of Hepatic Duct
DUE TO (c) Adenocarcinoma of Hepatic Duct | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) attending physician attended the deceased from 31 July 19 61 to 1 Aug 19 61 , that (I) was last saw the deceased alive on 1 Aug 19 61 , and that death occurred at 3:40 A from the causes and on the date stated above. | | | | | | | | | | |
| 22a. SIGNATURE
Herman I. Rosenberg | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
1 Aug 61 | | | |
| 22c. PHYSICIAN'S NAME (Type)
HERMAN I. ROSENBERG, Capt., M.C. | | | | | 22d. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5th Aug. 1961 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Margaret's Cem. | | | 23d. LOCATION (City, town, or county) (State)
Montgomery, Alabama | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
R. V. Driggle | | | | | ADDRESS
Glen Burnie, Md. | | 25a. REC'D BY REGISTRAR
DATE AUG 2 '61 | | 25b. REGISTRAR'S SIGNATURE
Carlton L. Hines | |

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL
ALBANY, N. Y.

1904

100

IN SENATE, JANUARY 10, 1904.

REPORT OF THE

STATE

OF NEW YORK

FOR THE YEAR 1903.

ALBANY, N. Y.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08763

8769

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort George G. Meade | | | | c. LENGTH OF STAY IN 1b
12 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
Kimbrough Army Hospital | | | | d. STREET ADDRESS
1425 Houghton Road | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Juliette Middle Payne Last Payne | | | | 4. DATE OF DEATH
Month August Day 30 Year 19 61 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
Cau | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
25 May 1898 | |
| 9. AGE (In years last birthday)
63 yrs. | | IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | | IF UNDER 24 HRS.
Hours <input type="checkbox"/> Min. <input type="checkbox"/> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
- | | 11. BIRTHPLACE (State or foreign country)
New York | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | |
| 13. FATHER'S NAME
Jeremiah Hefferman | | | | 14. MOTHER'S MAIDEN NAME
Josephine Messemer | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
- | | | | 16. SOCIAL SECURITY NO.
130-03-2855E | | 17. INFORMANT
Daughter - Mrs Lillian Schintz | |
| | | | | Address 1425 Houghton Rd | | Glen Burnie, Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary artery occlusion
DUE TO Rheumatic heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) -
(c) - | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
10 minutes |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Fracture of pelvis | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. <input type="checkbox"/> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that the deceased died death occurred at 4:55 A M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
Jules I. Kaplan | | | | ADDRESS (Street, city or town, state)
Kimrough Army Hosp Ft Geo G. Meade, Md | | | |
| PHYSICIAN'S NAME (Type)
JULES I. KAPLAN | | | | DATE SIGNED
30 Aug 61 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Buried | | 22b. DATE THEREOF
Sept 2-61 | | 22c. NAME OF CEMETERY OR CREMATORY
St Mary's Cemetery | | 22d. LOCATION (City, town, or county) (State)
Staten Island, New York | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Bernard A. Fink | | | | ADDRESS
Glen Burnie, Md | | 24a. REC'D BY REGISTRAR
SEP 1 '61 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Charles S. Harris | | | |

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8770

CERTIFICATE OF DEATH

Reg. Dist. No.

08764

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Tracy's Landing | | c. LENGTH OF STAY IN 1b
Life | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
---Deale Road--- | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First William Middle Owen Last Perry | | 4. DATE OF DEATH
Month August Day 9 Year 19 61. | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan. 21, 1880 |
| 9. AGE (In years last birthday)
81 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Ret. Tobacco Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Farm | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
William Perry | | 14. MOTHER'S MAIDEN NAME
Sallie Crandell | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No -- (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 218-12-9669 | |
| 17. INFORMANT
Madeline Perry Dorsey- | | Address Tracy's Landing, Maryland. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 442X Congestive Failure
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C.V.R. Disease
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
1 mo
15 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb , 1947, to Aug , 1961, that I last saw the deceased alive on 8 Aug , 1961, and that death occurred at 1:10 M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Upper Marlboro, Md. DATE SIGNED 8/9/61. | | | |
| ACTUAL SIGNATURE Robert B. Sasscer M.D. | | PHYSICIAN'S NAME (Type) R. B. Sasscer, M. D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/12/61 | |
| 22c. NAME OF CEMETERY OR CREMATORY St. James Cemetery | | 22d. LOCATION (City, town, or county) (State) Tracy's Landing, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Ritchie Bros. Fun'l Home-Upper Marlboro, Md. | | 24a. REC'D BY REGISTRAR
DATE AUG 22 '61 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur H. Hines | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers and return them to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. This certificate is valid for 10 days after death. It must be used as a burial-transit permit. File pages 1 and 2 with the Registrar for burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8771 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08765

Reg. Dist. No.

| | | | |
|---|---------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE California b. COUNTY Los Angeles | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena 43X-2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Anne Arundel General Hospital | | d. STREET ADDRESS 943 N. Hudson | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last JOHN H REAM | | 4. DATE OF DEATH Month Day Year AUGUST 8, 1961 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 30, 1891 |
| 9. AGE (In years last birthday) 70 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Bus driver | | 10b. KIND OF BUSINESS OR INDUSTRY City | |
| 11. BIRTHPLACE (State or foreign country) Ind. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 700 16 2727A | |
| 17. INFORMANT Mrs. Wilma V. Ream- Wife- same as # 2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 825X DUE TO <i>Murder by Fire</i>
Conditions, if any, which gave rise to immediate cause (b)
(c) DUE TO <i>Fire</i>
stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Cardiac Arrest</i> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>8/8/61 12 p.m.</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i> | |
| 20f. (City or town) <i>Pasadena</i> | | (County) <i>Los Angeles</i> (State) <i>California</i> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <i>Elmer G. Linhardt</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) Elmer G. Linhardt | | DATE SIGNED <i>8/8/61</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 22b. DATE THEREOF August 12, 61 | 22c. NAME OF CEMETERY OR CREMATORY To | 22d. LOCATION (City, town, or county) Pasadena, California (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping Funeral Home</i> | | ADDRESS Annapolis, Md. | |
| 24a. REC'D BY REGISTRAR <i>NGG 14 '61</i> | | DATE | |
| 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i> | | | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(M)

| | | | | | | | |
|------------------|--|---------------------|--|----------------------|--|--------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Death | |
| Place of Birth | | Usual Residence | | Cause of Death | | Manner of Death | |
| Occupation | | Education | | Medical History | | Present Illness | |
| Family History | | Social History | | Physical Examination | | Mental Examination | |
| Autopsy | | Disposition of Body | | Burial | | Remarks | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The hospital or attending physician completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|----------------------------------|--|---|--|--|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| Items: 8,9, Film # G292 8/4/61 pb 18772 18766 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Crownsville
c. LENGTH OF STAY IN 1b
4 years
7 mos. 16 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Crownsville State Hospital | | | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore
d. STREET ADDRESS
1029 N. Dallas Street
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
(Type or print)
Robert C. Reed | | | | | | 4. DATE OF DEATH
Month Day Year
8 1 19 61 | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1888
March 21, 1888 | | 9. AGE (In years last birthday)
73 | | IF UNDER 1 YEAR
Months Days
7 13 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Unknown | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Unknown | | | | 11. BIRTHPLACE (County & State, or foreign country)
Washington, D. C. | | | |
| 12. CITIZEN OF WHAT COUNTRY
U.S.A. | | | | | | | | | | | |
| 13. FATHER'S NAME
Unknown | | | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
Unknown | | | | | | 16. SOCIAL SECURITY NO.
215-09-3287 | | 17. INFORMANT
Hospital Records
Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO
Conditions, if any, which gave rise to immediate cause (b) Hypostatic Pneumonia
(c) 522X
DUE TO
(e), stating the underlying cause last. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Sudden
3 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
Chronic Brain Syndrome Associated with Generalized Arteriosclerosis | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
----- | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. _____
p.m. _____ 19 _____ | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
----- | | 20f. (City or town) (County) (State)
----- | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 11/25 1956 to 8/1 1961 , that (I) (we) last saw the deceased alive on 8/1 1961 , and that death occurred at 7:30 PM , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
L. Benedict, M. D. | | | | | | 22b. DATE
8/2/61 | | 22c. PHYSICIAN'S NAME (Type)
L. Benedict, M. D. | | | |
| 23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify)
BURIAL | | | | | | 23b. DATE THEREOF
8-5-61 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Calvary Cem. | | 23d. LOCATION (City, town or county) (State)
A. A. County Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
William E. Blackman | | | | | | 25a. REC'D BY REGISTRAR
AUG 4 61 | | 25b. REGISTRAR'S SIGNATURE
William E. Blackman | | | |

3 1 3
FOR STATE HEALTH DEPT. (M)
TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 1 3
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 118767

| | | | |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b
MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 12 Cheston Avenue | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 10 Annapolis
d. STREET ADDRESS 12 Cheston Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First FLORENCE Middle A. Last REICH | | 4. DATE OF DEATH
Month August Day 21 Year 19 61 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 19, 1883 |
| 9. AGE (In years last birthday) 78 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H ousewife | 11. BIRTHPLACE (State or foreign country) Virginia |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H ousewife | | 10b. KIND OF BUSINESS OR INDUSTRY H ome | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Francis Angelo | | 14. MOTHER'S MAIDEN NAME Sarah V. Walter | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Walter Reich- | | Address 210 Rhode Island Ave. Wash.D.C. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Tamponade
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rupture of Aortic Aneurysm.
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Partial | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Charles S. Petty | | DATE SIGNED 8/22/61 | |
| EXAMINER'S NAME (Type) Charles S. Petty, M.D. | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) B ural | | 22b. DATE THEREOF Aug. 25, 1961 | |
| 22c. NAME OF CEMETERY OR CREMATORY Arlington National | | 22d. LOCATION (City, town, or country) (State) Arlington Va. | |
| 23. FUNERAL DIRECTOR W.R. Frank Harris - Washington D.C. | | 24a. REC'D BY REGISTRAR AUG 24 '61 | |
| 24b. REGISTRAR'S SIGNATURE Arthur L. Harris | | 24c. REGISTRAR'S SIGNATURE | |

M

I

12 Chapin Avenue

12 Chapin Avenue

THORNTON

THORNTON

August 25

August 25

Female White

Female White

18

Female White

Female White

Female White

Female White

Charles Thompson

Thompson of North Carolina

parted

8/25/01

Charles E. Thompson

Wm. H. Thompson

Wm. H. Thompson

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8774

118768

| | | | | | | | | | | | | | |
|---|------|--|------|---|--|--------|------|-------|------|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville
c. LENGTH OF STAY IN 1b 5 mos. 2 years 18 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS 1129 Argyle Avenue
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) Della | | 4. DATE OF DEATH
Month 8 Day 9 Year 19 61 | | 5. SEX
Female | | | | | | | | | |
| 6. COLOR OR RACE
Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1881 | | | | | | | | | |
| 9. AGE (In years last birthday) 80 yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table> | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | Months | Days | Hours | Min. | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housework | | 10b. KIND OF BUSINESS OR INDUSTRY
----- | |
| IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | | | | | |
| Months | Days | Hours | Min. | | | | | | | | | | |
| 11. BIRTHPLACE (County & State, or foreign country)
Unknown | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Unknown | | | | | | | | | |
| 14. MOTHER'S MAIDEN NAME
Unknown | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
Unknown | | | | | | | | | |
| 17. INFORMANT
Hospital Records | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO (b) Malignancy of Thyroid
(c) -----
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome Associated with Cerebral Arteriosclerosis | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
----- | | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. ----- p.m. ----- 19 | | 20d. INJURY OCCURRED
While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
----- | | | | | | | | | |
| 20f. (City or town)
----- | | 20g. (County)
----- | | 20h. (State)
----- | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 2/21 , 1959 , to 8/9 , 1961 , that (I) (we) last saw the deceased alive on 8/9 , 1961 , and that death occurred at 1:45 from the causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE
L. Benedict, M. D. | | 22b. DATE SIGNED
8/9/61 | | 22c. PHYSICIAN'S NAME (Type)
L. Benedict, M. D. | | | | | | | | | |
| 22d. ADDRESS
Crownsville State Hospital, Maryland | | 23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | | | | | | | | | | |
| 23b. DATE THEREOF
8-15-61 | | 23c. NAME OF CEMETERY OR CREMATORY
University of Md. | | 23d. LOCATION (City, town or county) (State)
Balto. Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Wm. Reesett | | 25a. REC'D BY REGISTRAR
AUG 17 '61 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. House | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. This certificate has been signed by the attending physician and completed by the funeral director. The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

(M)

(I)

Ann Arbor

Greenville

Greenville State Hospital

Ohio

Female

Married

X

1881

30

Travel

Unknown

Historical

Unknown

Unknown

Historical Records

Unknown

General History

Religiosity of Thyroid

Grönke's Brain Syndrome Associated with Generalized Epileptiform Discharges

1911

1911

1911

1911

1911

1911

1911

X

Greenville State Hospital, Maryland

Revised, M. D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8775

CERTIFICATE OF DEATH

08769

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore City | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville | | | | c. LENGTH OF STAY IN 1b 1 mo. 15 days | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital | | | | d. STREET ADDRESS 1544 Pennsylvania Ave. | | | | | |
| 3. NAME OF DECEASED
(Type or print) Leroy Earl Savage | | | | 4. DATE OF DEATH
Month 8 Day 22 Year 19 61 | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
October 20, 1901 | | | |
| 9. AGE (In years last birthday) 59 yrs. | | IF UNDER 1 YEAR
Months 8 Days 22 | | IF UNDER 24 HRS.
Hours 19 Min. 61 | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook | | | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | | | | |
| 11. BIRTHPLACE (County & State, or foreign country) Florida | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME
Joseph Savage | | | | 14. MOTHER'S MAIDEN NAME
Alberta ? | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No (If yes give year or dates of service) | | | | 16. SOCIAL SECURITY NO. Unknown | | | | | |
| 17. INFORMANT Hospital Records | | | | Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
334X DUE TO Chronic Brain Syndrome Associated with Generalized Cerebral Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) -----
DUE TO (c) ----- | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Sudden
Since 7/7/61 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----- | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. ----- p.m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----- | | | |
| 20f. (City or town) ----- | | | | (County) ----- | | (State) ----- | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 7/7, 19 61 to 8/22, 19 61 that (I) (we) last saw the deceased alive on 8/22, 19 61 and that death occurred at 10:10 A.M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
L. Benedict, M. D. | | | | 22b. DATE SIGNED
8/22/61 | | | | | |
| 22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D. | | | | 22d. ADDRESS
Crownsville State Hospital, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Aug. 26-1961 | | 23c. NAME OF CEMETERY OR CREMATORY Mt Auburn Cem. | | 23d. LOCATION (City, town or county) Balto. Maryland | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Earl Gilmore | | | | 25a. REC'D BY REGISTRAR 519 M. Asher St | | | | | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Evans | | | | DATE AUG 24 '61 | | | | | |

(M)

Ann. 11/10/61

Crownsville

1 no. 15 days

Beltsville

Baltimore City

Crownsville State Hospital

1514 Pennsylvania Ave.

Barry

Barry

Barry

SS

8

21

Male

Age 20

X

October 30, 1961

32

Cook

Florida

U.S.A.

Joseph Savage

Alberta

Hospital Records

Unknown

No

Coronary Occlusion

Chronic Heart Symptoms associated with Coronary Occlusion
General arteriosclerosis

(I)

Admission

6/28/61

Crownsville State Hospital, Md.

I. Hamilton, M.D.

Handwritten notes:
Crownsville State Hospital, Md.
I. Hamilton, M.D.
6/28/61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and that it be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|---|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 8776 CERTIFICATE OF DEATH 08770 | | | | | | | | | | | |
| 1. PLACE OF DEATH
e. COUNTY <i>Anne Arundel</i> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE <i>District of Columbia</i>
b. COUNTY <i>District of Columbia</i>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> 47X-3 ✓
d. STREET ADDRESS <i>7047 Wyndale St., N. W.</i>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) <i>Edward Joseph Seiler</i> | | | | | | 4. DATE OF DEATH <i>August 18 1961</i> | | | | | |
| 5. SEX <i>Male</i> | | 6. COLOR OR RACE <i>White</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>June 10, 1893</i> | | 9. AGE (In years last birthday) <i>68</i> yrs. | | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sales Manager-Retired Machine Shop</i> | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Washington, D. C.</i> | | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i> | | |
| 13. FATHER'S NAME <i>John Seiler</i> | | | | | | 14. MOTHER'S MAIDEN NAME <i>Frances Frank</i> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes WW I</i> | | | | | | 16. SOCIAL SECURITY NO. <i>577-10-7862</i> | | | 17. INFORMANT (Wife) <i>Margaret F. Seiler</i> Address <i>Same as Item #2</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Scleroderma of heart, esophagus, and rectum</i>
710.0 DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <i>and rectum</i>
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
INTERVAL BETWEEN ONSET AND DEATH <i>over one year</i> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m. <i>19</i> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | 20g. (County) | | 20h. (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Aug 17, 1961</i> to <i>Aug 18, 1961</i> , that (I) (we) last saw the deceased alive on <i>Aug 17, 1961</i> , and that death occurred at <i>11:30 AM</i> , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <i>Willard F. Smith</i> M.D. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) <i>WILLARD F. SMITH, M.D.</i> | | | | | | 22d. ADDRESS <i>Shady Side, Md.</i> | | 22b. DATE SIGNED <i>8/18/61</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE THEREOF <i>8-21-61</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i> | | | | 23d. LOCATION (City, town or county) (State) <i>Prince George Co., Md.</i> | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>ROBERT A. PUMPHREY</i> ADDRESS <i>Bethesda, Md.</i> | | | | | | 25a. RECEIVED BY REGISTERAR <i>AUG 22 1961</i> | | 25b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i> | | | |

10770

0770

(M)

Edward Joseph
Male White

Washington

1907

Edward Joseph
Male White
June 10, 1907

(1)

John Taylor

Francis Evans

1910-1911

Yes

Substantive et al.

Washington

George Washington

WILLARD F. SMITH, JR.
1910-1911

1
R

ROBERT A. BROWN
1910-1911
George Washington

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death occurs at the hospital or at the residence of the deceased, the certificate may be retained by the hospital or attending physician. If the death occurs elsewhere, the certificate may be retained by the funeral director. This certificate has been signed by the attending physician or funeral director. If the certificate is to be used for burial or cremation, it must be signed by the funeral director. If the certificate is to be used for other purposes, it must be signed by the attending physician or funeral director. This certificate should be detached for use as the burial-transit permit. Then please remove card 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|--|--|---|---|---|---|---|---|---|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | |
| 8777 | | | | | | | | | | | | | | |
| 18771 | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | | | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Annapolis | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Annapolis | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Anne Arundel General Hospital | | | | | d. STREET ADDRESS
16 Maryland Ave. | | | | | | | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First J. Middle Norman Last SMITH | | | | | 4. DATE OF DEATH
Month August Day 14 Year 1961 | | | | | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Nov. 1, 1887 | | 9. AGE (In years last birthday)
73 yrs. | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
REAL ESTATE | | 10b. KIND OF BUSINESS OR INDUSTRY
REAL ESTATE | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | | | | | | | | |
| 13. FATHER'S NAME
JAMES S. SMITH | | | | | 14. MOTHER'S MAIDEN NAME
OLIVIA LUBBS | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT
Address Mrs Grace S. Beachley (2) | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Squamous cell ca
163X DUE TO
Conditions, if any, which gave rise to immediate cause (b) 1 lung
(e), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Pulmonary fibrosis | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
6 min | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m.
19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (husband) attended the deceased from Apr 6/ 19 61 , to Aug. 14, 19 61 , that (I) (w) last saw the deceased alive on Aug. 14, 19 61 , and that death occurred at M , from the causes and on the date stated above. | | | | | | | | | | | | | | |
| 22a. SIGNATURE
Frank M. Shipley | | | | | 22b. DATE
8/15/61 | | 22c. PHYSICIAN'S NAME (Type)
Frank M. Shipley | | | | | | | |
| 22d. ADDRESS
121 Cathedral St., Annapolis, Md. | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE THEREOF
8-17-1961 | | 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest Memorial | | 23d. LOCATION (City, town or county) (State)
Annapolis Md | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
John M. Taylor, Sr. Annapolis Md | | | | | 25a. REC'D BY REGISTRAR
DATE AUG 18 '61 | | 25b. REGISTRAR'S SIGNATURE
John S. K... | | | | | | | |



10771

10772

James S. Smith
10 H. V. Road
Nov. 1, 1937

James S. Smith
10 H. V. Road

James S. Smith
10 H. V. Road
Nov. 1, 1937

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased is not in the hospital or attending physician's office, the certificate may be retained by the hospital or attending physician and filed in by the funeral director. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is complete. The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carefully, and in any event, within 72 hours after death. be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8778

CERTIFICATE OF DEATH

Item 7 Film G293 8/24/61 mh

08772

| | | | | | |
|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Anne Arundel
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Crownsville
c. LENGTH OF STAY IN 1b
21 years 8 mos. 14 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Crownsville State Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Wicomico
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Fruitland
d. STREET ADDRESS
Unknown | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Mamie
First Middle Last
Smith | | 4. DATE OF DEATH
Month Day Year
8 16 61 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
Negro | | 7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
1904 | | 9. AGE (In years last birthday) yrs.
57 | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY
----- | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
William Wright | | 14. MOTHER'S MAIDEN NAME
Alverta Williams | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
Unknown | | 17. INFORMANT
Hospital Records
Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Circulatory Collapse
DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Hypostatic Pneumonia
DUE TO
(c) | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e):
Chronic Brain Syndrome Associated with Convulsive Disorder | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
----- | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour e.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
----- | |
| 20f. (City or town)
----- | | 20g. (County)
----- | | 20h. (State)
----- | |
| 21. I certify that (I) (this hospital) attended the deceased from 12/2 , 19 39 to 8/16 , 19 61 , that (I) (we) last saw the deceased alive on 8/16 , 19 61 , and that death occurred at 2 AM , from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
[Signature] | | M.D.
L. Benedict, M.D. | | 22b. DATE
8/16/61 | |
| 22c. PHYSICIAN'S NAME (Type)
L. Benedict, M.D. | | 22d. ADDRESS
Crownsville State Hospital, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Removed | | 23b. DATE THEREOF
8/18/61 | | 23c. NAME OF CEMETERY OR CREMATORY
Calvary Cemetery | |
| 23d. LOCATION (City, town or county)
Baltimore Maryland | | 23e. REC'D BY REGISTRAR
AUG 21 '61 | | 23f. REGISTRAR'S SIGNATURE
Arthur S. Hunt | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
[Signature] | | 24b. ADDRESS
108 W. W. St. E. Baltimore | | | |

8778

8778

M

Unknown

Unknown

Unknown

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Unknown

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Unknown

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is to be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|--|----------------------------------|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | |
| 8779 | | | |
| CERTIFICATE OF DEATH | | | |
| 08773 | | | |
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Annapolis | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Annapolis | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Anne Arundel General Hospital | | d. STREET ADDRESS
610 Sixth St. | |
| 3. NAME OF DECEASED (Type or print)
ALSO (Lee Hampton Spencer) | | 4. DATE OF DEATH
Month August Day 29 Year 1961 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April 6, 1915 |
| 9. AGE (In years last birthday)
46 yrs. | | IF UNDER 1 YEAR
Months 46 Days 29 Hours 19 Min. 61 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY
Bldg. Construction | |
| 11. BIRTHPLACE (County & State, or foreign country)
Pilaski, Virginia | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Lee H. Spencer | | 14. MOTHER'S MAIDEN NAME
Josie B. Owen | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO. 214 05 0865 | |
| 17. INFORMANT
Mrs Lucile F. Spencer- Wife- same as # 2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Delirium tremens
DUE TO
(b) Acute alcoholism
DUE TO
(c) Chronic alcoholism
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. 19
p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (MRS. HOSPITAL) attended the deceased from Aug. 25, 1961, to Aug. 29, 1961 that (I) (MRS.) saw the deceased alive on Aug. 29, 1961 , and that death occurred at 3:20 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
G. Church | | 22b. DATE SIGNED
8/31/61 | |
| 22c. PHYSICIAN'S NAME (Type)
G. CHURCH | | 22d. ADDRESS
121 Cathedral St., Annapolis, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Aug. 31, 1961 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | | 23d. LOCATION (City, town or county) (State)
Prince George Co. Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Hopping Funeral Home | | 25a. REC'D BY REGISTRAR
SEP 5 '61 | |
| ADDRESS
Annapolis, Md. | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Huns | |

3773



Time removed

4250 (Lee Hampton)

Carpenter
Lee H. Spencer
Black. Construction Alaska, Virginia
Jodie B. Owen
USA

no

214 05 0865

The Jodie B. Spencer - life - same as

Aug. 29, 31

Burial
Apr. 31, 1961 Fort Lincoln Cemetery
Annapolis, Md.
Princess George's Co. Maryland
Set 2 61

10774

Unknown

Unknown

Unknown

30 yrs. 6 days

Unknown

Unknown

Unknown

10

Unknown

Unknown

Unknown

June 2, 1921

Unknown

10

Unknown

Unknown

Unknown

Unknown

Unknown

Unknown

Unknown

Terminal coronary thrombosis

10

Myocardial heart disease

10

Myocardial heart disease associated with congenital coronary disease - 10

Coronary artery disease associated with congenital anomaly

10

10

10

10

10

10

10

10

10

10

Unknown

Unknown

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased may be retained in the hospital or attending physician's office, this certificate has been signed by the attending physician and completely filled in by the funeral director. If the deceased is to be buried, this certificate should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|---|--|--|---|--|--|--|
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | |
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | | |
| 8781 - Item 14 Film 0295 9/14/61 ink | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH 08775 | | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
Anne Arundel
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Crownsville
c. LENGTH OF STAY in b.
19 years 1 mo. 24 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Crownsville State Hospital | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore City
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Baltimore
d. STREET ADDRESS
625 Archer Street
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
Sarah Louisa Stewart | | | 4. DATE OF DEATH
Month 8 Day 9 Year 1961 | | | 5. SEX
Female | | | 6. COLOR OR RACE
Negro | | | | | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH
December, 1874 | | | 9. AGE (In years last birthday)
86 yrs. | | | IF UNDER 1 YEAR
Months 8 Days 9 | | IF UNDER 24 HRS.
Hours 19 Min. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
----- | | | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
William Ralley | | | | | | 14. MOTHER'S MAIDEN NAME
Harriette Cromwell | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
Unknown | | | | 16. SOCIAL SECURITY NO.
Unknown | | | | 17. INFORMANT
Hospital Records
Address | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gangrene of Left Leg
450.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b) Generalized Arteriosclerosis
(a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
----- | | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. ----- p.m. 19 | | | | 20d. INJURY OCCURRED
While <input checked="" type="checkbox"/> Not at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
----- | | 20f. (City or town)
----- | | (County)
----- | | (State)
----- | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 6/28/40 to 8/9 , 1961, that (I) (we) last saw the deceased alive on 8/9 , 1961, and that death occurred at 7:45 from the causes and on the date stated above. | | | | | | | | | | | | | | | |
| 22a. SIGNATURE
L. Benedict, M. D. | | | | | | 22b. DATE
8/10/61 | | | 22c. PHYSICIAN'S NAME (Type)
L. Benedict, M. D. | | | 22d. ADDRESS
Crownsville State Hospital, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE THEREOF
8/14/61 | | 23c. NAME OF CEMETERY OR CREMATORY
Not in burials | | | | 23d. LOCATION (City, town or county) (State)
Baltimore Md. | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Charles A Rice | | | | | | ADDRESS
661 Bowie St | | | 25a. REG. BY REGISTRAR
AUG 16 61 | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Krawt | | | | |

(M)

(1)

Anna Arnold

Crownsville

Crownsville State Hospital

1 mo. 24 days

Baltimore

Maryland

Baltimore City

425 Archer Street

Louis

Stewart

8

9

21

86

December, 1974

Maryland

Baltimore

Hospital records

Unknown

Unknown

Gangrene of left leg

Generalized arteriosclerosis

61

8/9

6/28 to 10/29

61

8/9

8/9/74

Crownsville State Hospital, Maryland

L. Benedict, M.D.

Class 1

10/1/81

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8782

Item 3 Film G293 8/16/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

18776

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Harold Harbor, Crownsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Harold Harbor, Crownsville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Lake Path | | d. STREET ADDRESS
Lake Path | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First MAX Middle TANNHAUSER Last Tannhauser | | 4. DATE OF DEATH
Month August Day 5 Year 1961 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Unknown 1891 |
| 9. AGE (In years last birthday)
70 yrs. | | IF UNDER 1 YEAR
Months 70 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Ret. | | 10b. KIND OF BUSINESS OR INDUSTRY
Unknown | |
| 11. BIRTHPLACE (State or foreign country)
Germany | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
190 07 771 A | |
| 17. INFORMANT
Mrs Edith E. Ball - Lake Trail, Crownsville, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Failure
DUE TO Sclerotic Cardiovascular Disease?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) —
DUE TO —
(c) — | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) — | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
— | |
| 20c. TIME OF INJURY
Month — Day — Year 19
Hour — a. m. — p. m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
— | | 20f. (City or town) (County) (State)
— | |
| 21. I certify that I attended the deceased from Aug 27, 1961 to 8/2, 1961 , that I last saw the deceased alive on 8/2, 1961 , and that death occurred at M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 609 Odenton Rd, Del 6/1/61 DATE SIGNED OR 47710 | | | |
| ACTUAL SIGNATURE Febus F. Grunberg M.D. | | PHYSICIAN'S NAME (Type) Febus F. Grunberg MD Odenton, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 22b. DATE THEREOF
Aug. 8, 1961 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln | | 22d. LOCATION (City, town, or county) (State)
Prince George County Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Hopping Funeral Home | | ADDRESS
Annapolis, Md. | |
| 24a. REC'D BY REGISTRAR
AUG 9 '61 | | 24b. REGISTRAR'S SIGNATURE
— | |

CERTIFICATE OF DEATH

8132

| | | | | | | | | | |
|------------------------|--|------------------------|--|------------------------|--|----------------------|--|-----------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | |
| John Doe | | Male | | 45 | | Jan 15, 1920 | | Baltimore, Md. | |
| Cause of Death | | Manner of Death | | Occupation | | Education | | Religion | |
| Heart Disease | | Natural | | Teacher | | High School | | Catholic | |
| Date of Death | | Time of Death | | Place of Death | | Physician | | Hospital | |
| Jan 20, 1965 | | 10:30 AM | | Home | | Dr. Smith | | St. Mary's | |
| Signature of Physician | | Signature of Registrar | | Signature of Informant | | Signature of Coroner | | Signature of Burial Officer | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |

1
M
010
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and is complete. It is to be filled in by the funeral director. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is complete. It is to be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8783
CERTIFICATE OF DEATH
08777

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Crownsville
c. LENGTH OF STAY in 1b
20 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Crownsville State Hospital | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE
Pennsylvania
f. COUNTY
Unknown
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Philadelphia
d. STREET ADDRESS
810 Madison Avenue
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Daniel | | 4. DATE OF DEATH
Month
8
Day
30
Year
19 61 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
October 4, 1891 |
| 9. AGE (In years last birthday)
69 yrs. | IF UNDER 1 YEAR
Months
8
Days
30 | IF UNDER 24 HRS.
Hours
19
Min.
61 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Plummer | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
John F. Thomas | | 14. MOTHER'S MAIDEN NAME
Ester? | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes no, or unknown) (If yes give year or dates of service)
Yes World War I | | 16. SOCIAL SECURITY NO.
184-07-7320 | |
| 17. INFORMANT
Hospital Records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardio Vascular Disease
DUE TO Hypertension
(b) General Arteriosclerosis
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
----- | |
| 21c. TIME OF INJURY
Month, Day, Year
Hour a.m. -----
p.m. 19 | 22d. INJURY OCCURRED
While <input checked="" type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/> | 22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
----- | 22f. (City or town)

(County)

(State)
----- |
| 21. I certify that (I) (this hospital) attended the deceased from 8/10 , 19 61 , to 8/30 , 19 61 , that (I) (we) last saw the deceased alive on 8/30 , 19 61 , and that death occurred 12-10-61 from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
L. Benedict, M. D. | | 22b. DATE SIGNED
8/30/61 | |
| 22c. PHYSICIAN'S NAME (Type)
L. Benedict, M. D. | | 22d. ADDRESS
Crownsville State Hospital, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
9/2/61 | 23c. NAME OF CEMETERY OR CREMATORY
BALTO Nat. Cem. | 23d. LOCATION (City, town, or county)
BALTO CITY
(State)
----- |
| 24. FUNERAL DIRECTOR'S SIGNATURE
C. O. Wilson | | 25. REC'D BY REGISTRAR
DATE SEP 1 '61 | |
| ADDRESS
1000 Brantley Ave. | | 25b. REGISTRAR'S SIGNATURE
William L. Travis | |

7777

3333

(M)

January

February

March

April

May

June

July

August

September

October

November

December

U.S.A.

British

French

German

Italian

Japanese

1917-1918

Yes

(I)

1917

1918

1919

1920

1921

1922

1923

1924

Greenwich State Hospital

L. Bonnet, M.D.

1925

U.S. Bureau of Census

may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers on pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G300 11/16/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

118778

3784

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel County MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's Co. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup | | | | c. LENGTH OF STAY IN 1b 5 mo. 4 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro, Maryland | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maryland House of Correction Hospital | | | | d. STREET ADDRESS 2510 Browns Station Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First John Middle Arthur Last Thomas | | | | 4. DATE OF DEATH
Month August Day 12 Year 1961 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH November 2, 1910 | |
| 9. AGE (In years last birthday) 50 yrs. | | IF UNDER 1 YEAR
Months 50 Days 0 Hours 0 Min. 0 | | IF UNDER 24 HRS.
Months 0 Days 0 Hours 0 Min. 0 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Richard E. Thomas | | | | 14. MOTHER'S MAIDEN NAME Lydia Queen | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 1942-1947 | | | | 16. SOCIAL SECURITY NO. 579 14 3603 | | 17. INFORMANT Address Maryland House of Correction, Jessup, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) myocardial Infarction
420.1 DUE TO Coronary Thrombosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease
(c) Arteriosclerotic Cardiovascular Disease | | | | | | INTERVAL BETWEEN ONSET AND DEATH
22 days
22 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. 11 p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 7-21 , 19 61 , to 8-12 , 19 61 , that I last saw the deceased alive on 8-11 , 19 61 , and that death occurred at 6 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Jose M. Yosuico M.D. | | | | ADDRESS (Street, city or town, state) RFD #1 Jessup, Maryland DATE SIGNED 8-12-61 | | | |
| PHYSICIAN'S NAME (Type) Jose M. Yosuico, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-16-61 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington National | | 22d. LOCATION (City, town, or county) (State) Arlington Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Myrtle R. Collins ADDRESS Wash., D.C. 4339 Hunt Pl., N.E. | | | | 24a. REC'D BY REGISTRAR AOG 16 '61 DATE | | 24b. REGISTRAR'S SIGNATURE Arthur S. Frank | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8785

CERTIFICATE OF DEATH

Reg. Dist. No. 08779

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Annapolis | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Annapolis | | | |
| c. LENGTH OF STAY IN 1b
50 yrs. | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
623 Second Street | | | | d. STREET ADDRESS
623 Second Street | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
HANNAH ANN MurTay Thompson | | | | 4. DATE OF DEATH
Month Day Year
August 31 19 61 | | | |
| 5. SEX
F. | | 6. COLOR OR RACE
C | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Nov. 4- 1872 | |
| 9. AGE (In years last birthday)
88 | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | | 11. BIRTHPLACE (State or foreign country)
Annapolis, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Domestic | | | | 10b. KIND OF BUSINESS OR INDUSTRY
***** | | | |
| 13. FATHER'S NAME
Daniel Crowdy | | | | 14. MOTHER'S MAIDEN NAME
Elizabeth Gross | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
Address
Leona Carroll-422 Chester Ave Anna, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage due to
443X DUE TO arteriosclerotic Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3 months
DUE TO Uncertain disease
(c) Uncertain disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m.
p. m.
19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 1, 1961 to August 31, 1961 , that I last saw the deceased alive on August 31, 1961 , and that death occurred at 110 Clay St. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE R.L. Richardson | | | | ADDRESS (Street, city or town, state) 110 Clay Street Annapolis, Md. | | | |
| PHYSICIAN'S NAME (Type) R.L. Richardson | | | | DATE SIGNED SEP 6 1961 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
9-3-61 | | 22c. NAME OF CEMETERY OR CREMATORY
Brewer Hill | | 22d. LOCATION (City, town, or county) (State)
Annapolis, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
C.E. Hicks III | | | | ADDRESS
Annapolis, Md. | | 24a. REC'D BY REGISTRAR
SEP 6 '61 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Kneass | | | |

TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please refer to the Medical Examiner's Office. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

FOR STATE
HEALTH DEPT.

Items 18-61 Film 296
19-26-61
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8786

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18780

| | | | |
|---|----------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
10 Annapolis | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Anne Arundel General Hospital | | d. STREET ADDRESS
1 9 Oak Court | |
| 3. NAME OF DECEASED
(Type or print)
First LEROY Middle C. Last THOMPSON | | 4. DATE OF DEATH
Month August Day 16 Year 1961 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10-17-1918 |
| 9. AGE (In years last birthday)
42 yrs. | | IF UNDER 1 YEAR
Months 4 Days 12 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Electrician Helper U.S.N. ACADEMY | | 10b. KIND OF BUSINESS OR INDUSTRY
LOUISVILLE KY | |
| 11. BIRTHPLACE (State or foreign country)
U.S.A. | | 12. CITIZEN OF WHAT COUNTRY
U.S.A. | |
| 13. FATHER'S NAME
JOHN THOMPSON | | 14. MOTHER'S MAIDEN NAME
MINNIE EVANS | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) yes WW II | | 16. SOCIAL SECURITY NO.
DORIS E THOMPSON | |
| 17. INFORMANT
(2) | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Electrocution
914.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Working with defective lamp cord and electric tools in damp crawl space beneath his house | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. 2 p.m. 8/16/ 1961 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | | 20f. (City or town) (County) (State)
Anne Arundel Md | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Howard Shaub | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
Howard Shaub, M.D. | | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| | | Address (Street, city, town, or county)
8/16/61 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Aug 19 1961 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Cedar Bluff Cem | | 22d. LOCATION (City, town, or country) (State)
Annapolis Md. | |
| 23. FUNERAL DIRECTOR
John M. Taylor Sons | | 24a. REC'D BY REGISTRAR
AUG 22 '61 | |
| | | 24b. REGISTRAR'S SIGNATURE
Charles S. Haux | |

100-10000

100-10000

(M)

Married

Married

Married

Married

Married

100-10000

100-10000

White

100-10000

100-10000

Robert Sharp, N.Y.

100-10000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After if the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G293 8/25/61 mb

8787

CERTIFICATE OF DEATH

Reg. Dist. No.

08781

| | | | |
|---|-------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <i>A. A.</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
b. STATE <i>Ind.</i> c. COUNTY <i>A. A.</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <i>80 Charles St.</i> | |
| 3. NAME OF DECEASED (Type or print) <i>Frank</i> First <i>R.</i> Middle <i>Tucker</i> Last | | 4. DATE OF DEATH <i>Aug 10 1961</i> Month <i>Aug</i> Day <i>10</i> Year <i>1961</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>Color</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Feb 18 1911</i> |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i> | | 9b. AGE (In years last birthday) <i>50 5/11</i> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Int. Sterling Key</i> | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <i>Dr. Robert Heese</i> | | 14. MOTHER'S MAIDEN NAME <i>Louise Russell</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <i>220-24-1079</i> | |
| 17. INFORMANT <i>Robert Tucker</i> | | Address <i>Annapolis</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>171X</i> Bronchogenic Metastatic Carcinoma
DUE TO Carcinoma of Cervix
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i>
<i>5 yrs.</i> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>July 20, 1956</i> to <i>Aug. 10, 1961</i> , that I last saw the deceased alive on <i>August 10, 1961</i> , and that death occurred at <i>10:30 A.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Theodore H. Johnson M.D.</i> | | ADDRESS (Street, city or town, state) <i>37 Calvert Street</i> DATE SIGNED <i>August 21, 1961</i> | |
| PHYSICIAN'S NAME (Type) <i>Theodore H. Johnson, M. D.</i> | | <i>Annapolis, Maryland</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Aug 13 1961</i> | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i> | | 22d. LOCATION (City, town, or county) (State) <i>Annapolis Ind.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Johnson</i> | | ADDRESS <i>Annapolis</i> | |
| 24a. REC'D BY REGISTRAR <i>AUG 22 61</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur H. Johnson</i> | |

2858

(M)

(1)

Handwritten signature
Handwritten signature

Handwritten signature

Handwritten signature

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8785

CERTIFICATE OF DEATH

Reg. Dist. No.

08783

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Anne Arundel | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE
Maryland
b. COUNTY
Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural Annapolis | | | | c. LENGTH OF STAY IN 1b
X | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Cape St. John | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
JANE G WALLACE | | | | 4. DATE OF DEATH
Month Day Year
AUGUST 14 19 61 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Aug 25, 1905 | |
| 9. AGE (In years last birthday)
55 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | | 11. BIRTHPLACE (State or foreign country)
Springhill, Novascotia | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House wife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
own home | | | |
| 13. FATHER'S NAME
Philip Gaudet | | | | 14. MOTHER'S MAIDEN NAME
Elizabeth THIBODEAU | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
818 03 0437 | | 17. INFORMANT
Address
Mr. Franklin O. Wallace—Husband—same as # 2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Anaplastic tumor of retroperitoneal lymph nodes
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____
INTERVAL BETWEEN ONSET AND DEATH
4 mos. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Sept. 145 , to Aug. 14 , 19 61 , that I last saw the deceased alive on 8/14/61 , 19 61 , and that death occurred at 2: P. M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) _____ DATE SIGNED 8/16/61 | | | | | | | |
| ACTUAL SIGNATURE S. Borssuck M.D. _____ | | | | | | | |
| PHYSICIAN'S NAME (Type) S. Borssuck MD Amos Garrett Blvd. Annapolis, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Aug. 17, 61 | | 22c. NAME OF CEMETERY OR CREMATORY
St. Mary's Cemetery | | 22d. LOCATION (City, town, or county) (State)
Annapolis, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Hopping Funeral Home
ADDRESS Annapolis, Md. | | | | 24a. REC'D BY REGISTRAR
DATE AUG 18 '61 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kneale | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. page 3 should be detached for the burial-transit permit. Then please remove carbon papers.

CERTIFICATE OF DEATH

1922

M

1



X

8790

08784

| | | | | | |
|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>A.A.</u> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>AA.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Handled.</u> | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Handled.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DEEP CREEK</u> | | | | d. STREET ADDRESS <u>DEEP CREEK</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Joseph E. Wallace</u> | | | | 4. DATE OF DEATH <u>8-16-1961</u> | |
| 5. SEX <u>M.</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH <u>7-5-79</u> | | 9. AGE (In years last birthday) <u>81</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME <u>Daniel W. Haley</u> | | 14. MOTHER'S MAIDEN NAME <u>Anna Boldin</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Family. Jane</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac failure</u>
<u>286.5</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bilateral hypostatic pneumonia</u>
DUE TO (c) <u>Senility & malnutrition</u> | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 days</u>
<u>5 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May</u> 19 <u>61</u> to <u>August</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>August 16</u> 19 <u>61</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE <u>Bertrand C.R. Gau</u> | | 22b. PHYSICIAN'S NAME (Type) <u>Bertrand C.R. GAU</u> | | 22c. ADDRESS <u>RED 4 - Annapolis Md.</u> | |
| 22d. DATE <u>8/19</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF <u>8-19-61</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Lecky Hill</u> | |
| 23d. LOCATION (City, town, or county) (State) <u>Edinboro Md</u> | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>W.C. Kelly</u> | | 24a. ADDRESS <u>130 E. Fort Ave.</u> | | 24b. REC'D BY REGISTRAR <u>Aug 21 '61</u> | |
| 24c. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u> | | | | | |

8780

CERTIFICATE OF DEATH

1958

(V)

(T)

CHURCHILL

NOV 10 1958

ALBANY

DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8791 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08785

FOR STATE
HEALTH DEPT.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)
a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Linthicum</u> | | c. LENGTH OF STAY IN 1b
<u>Few seconds</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Washington</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give address)
<u>Jet. United Airlines, flight 808, Airport.</u> | | | | d. STREET ADDRESS
<u>1819 G. Street, N.W.</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Ralph</u> Middle <u>Wong</u> Last <u>Wong</u> | | | | 4. DATE OF DEATH
Month <u>August</u> Day <u>25th</u> Year <u>1961</u> | | | |
| 5. SEX
<u>M.</u> | | 6. COLOR OR RACE
<u>Yellow</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 8. DATE OF BIRTH
<u>10/22/92</u> | | 9. AGE (In years last birthday)
<u>68</u> yrs. | | IF UNDER 24 HRS.
Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>C.I.A.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>San Francisco, Cal.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>San Francisco, Cal.</u> | | | |
| 13. FATHER'S NAME
<u>LUNG WONG</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Lee</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT
Address <u>Wallet found on deceased.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic and hypertensive cardiovascular disease</u>
(a), stating the underlying cause last. DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
<u>Charles S. Petty</u> | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED
<u>8/26/61</u> | | | |
| EXAMINER'S NAME (Type)
<u>Charles S. Petty</u> | | Address (Street, city, town, or county) | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Removal-Burial</u> | | 22b. DATE THEREOF
<u>8/27/61</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Joseph Gawlee's Sons</u> | | | |
| 22d. LOCATION (City, town, or country) (State)
<u>SAN FRANCISCO CALIF.</u> | | 24a. REC'D BY REGISTRAR <u>Aug 29 '61</u> 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hume</u> | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further action is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

10/27/52

Charles E. Perry

VR A15 (4)
15M 9/60

| | | | | | |
|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Anne Arundel | | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
e. STATE
Maryland | | b. COUNTY
Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Annapolis | | c. LENGTH OF STAY IN 1b
2 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
RURAL - Edgewater | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Anne Arundel General Hospital | | d. STREET ADDRESS
Rt-1, Box-94 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Margaret | | First
WRIGHT | | Middle
August | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
July 27, 1925 | | 9. AGE (In years last birthday)
36 yrs. | | 10. IF UNDER 1 YEAR
Months 36 Days 0 | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | | 13. FATHER'S NAME
James Franklin Taylor | |
| 14. MOTHER'S MAIDEN NAME
Eleanor Ireland | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
no | | 16. SOCIAL SECURITY NO.
21916 0255 | |
| 17. INFORMANT
Mrs. J.F. Taylor- Mother, Lothian, Maryland | | 18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary edema -
Acute Renal Shut down
Stage IV epidermoid Cervical Carcinoma
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
171X
DUE TO (b)
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
3 days
18 mos | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 21. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 22a. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | 22b. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
4:03 PM | |
| 22d. (City or town)
April | | 22e. (County)
1961 | | 22f. (State)
Aug. 24, 1961 | |
| 23. I certify that (I) (this hospital) attended the deceased from April , 19 61 to Aug. 24 , 19 61 , that (I) (we) saw the deceased alive on Aug. 24 , 19 61 , and that death occurred at 4:03 PM , from the causes and on the date stated above. | | 24. SIGNATURE
Stuart M. Christhilf, Jr. | | 25. DATE
Aug 29 1961 | |
| 26. PHYSICIAN'S NAME (Type)
Stuart M. Christhilf, Jr. | | 27. ADDRESS
69 Franklin St., Annapolis, Md. | | 28. DATE
Aug 29 1961 | |
| 29a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 29b. DATE THEREOF
August 27, 61 | | 29c. NAME OF CEMETERY OR CREMATORY
Christ Episcopal Cemet. | |
| 29d. LOCATION (City, town or county)
Owensville, Maryland | | 29e. (State)
Md. | | 29f. REGISTRAR'S SIGNATURE
Arthur S. Evans | |
| 30. FUNERAL DIRECTOR'S SIGNATURE
Hopping Funeral Home | | 30a. ADDRESS
Annapolis, Md. | | 30b. REGISTRAR'S SIGNATURE
Arthur S. Evans | |

(M)

1933

1933

x

George Henry Ford
1933-1934
1935-1936

George Henry Ford

George Henry Ford

(M)

(1)

8793

05304

NAME UNKNOWN

AMT 2-2

1 X SHAW ST

STANISLAW ST (W) 1

1 WHITE

HOUSE WIFE

JOHN IMPROVING

POLAND

MARY

THEORETIC TINKER 423 CHESTER ST

Governing the various

Center for the poor

AVE 19

JAMES R. MARTIN

Church of the Holy Spirit 412 CHESTER ST

8-24-1901 HOLY SPIRIT CHURCH

2 SHAW ST

X

24-18-01

2-11-01